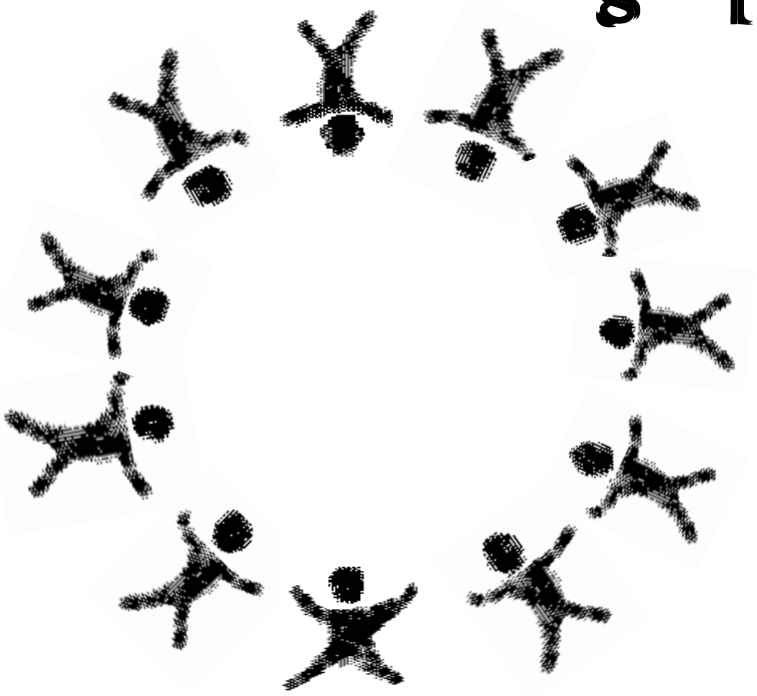
Educating Special Students in Tennessee



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Executive Summary

Special education is a highly complex field, every aspect of which is affected by federal and state legislation, accompanying rules and regulations, and court decisions. The U.S. Congress passed Public Law 94-142 in 1975, firmly establishing the federal government's role in mandating education for children with disabilities. Basically, P.L. 94-142 requires that all children must receive a free and appropriate education without cost to their parents, regardless of the severity or type of disability. The law ensures that students must be educated in the least restrictive environment possible, that they are ensured due process rights, and that an individualized education program must be developed for each student. The law was reauthorized in 1990 and was retitled the Individuals with Disabilities Education Act, or IDEA.

This report examines a few of the many issues encompassed by special education: trends, funding and funding methods, data collection, inclusion, assistive technology, health care procedures in schools, and discipline. Following is a brief summary of the conclusions reached and the recommendations made concerning each of these categories, as well as an abbreviated response from the Department of Education and, where applicable, the State Board of Education. (See Appendix I for complete responses from the Department and the Board.)

Trends

The number of children in Tennessee being served by special education has increased at a rate much greater than that of the student population as a whole. The growth in the number of children identified as having disabilities is more than double the growth in average daily membership. Tennessee has served a higher percentage of children with disabilities than both the nation and the Southeast for each school year from 1987-88 to 1992-93 (the year for which the most recent federal data is available). (See pages 4-8.)

Recommendation: The Department of Education and the State Board of Education should analyze special education data periodically to determine the extent to which actual variations exist, the consistency in data procedures, and the appropriate course of action to take where numbers of special education students significantly increase or decrease. Funding and services are dependent on accurate counts of children from all systems. (See page 8.)

Response: The Department concurs with the recommendations on "trends" and "data collection." The Department indicates that previous analyses of special education data reveal a small error rate. They propose to improve the data by utilizing additional methods of analysis. (See page 86.)

In addition, the State Board of Education agrees that they "have a role to play in analyzing the special education data and insisting that the Department collect and compile accurate information on which to base program and funding decisions." (See page 85.)

Funding and Funding Methods

In 1993-94, the most recent year for which state data is available, Tennessee spent a total of $277,738,307 on special education, according to the Department of Education's *Annual Statistical Report*. Of this, $52,919,550, or 19 percent, was provided through federal funding; the remainder, $224,818,757, or 81 percent, was provided through state and local funding.

The type of funding formula used to generate special education funds can affect the number and type of children served, the programs and services provided by local districts, the amount of time students spend in special education programs, placement of students in various programs, class size, and caseloads. Ongoing debate continues over the best funding method to use to avoid over- or under-identification of special education students. (See pages 9-10.)

The method used by the federal government to distribute funds to states for special education—essentially, the same amount is generated per special education student regardless of disability—has been criticized for creating an incentive for states to classify more students as special education to increase the amount of federal funding. Tennessee's method—which generates money based on the services each child receives—has been said to create an incentive for local education agencies to place special education children in more restrictive options in order to generate more state funding. However, analysis of data since inception of the Basic Education Program (BEP) does not indicate a shift from less expensive to more expensive options. Rather, the increases in options follow no obvious pattern. (See pages 10-18.)

The National Association of State Boards of Education suggests using a formula based on the national average of individuals with disabilities. This would alleviate under- or over-identification, since funding would not be based on actual counts of children with disabilities. (See page 18.)

Recommendations: OEA staff recommends that the Board and the Department consider using a formula for funding special education that is based on the national average of individuals with disabilities, such as NASBE advocates.

In addition, the State Board of Education should establish a limit on local costs for special education and provide for state assumption of costs in excess of this limit, as required by *Tennessee Code Annotated* §49-1-302(h). The limit should be sufficiently high to provide an incentive for LEAs to apply cost controls while providing necessary services identified by students' multi-disciplinary teams and recorded in their IEPs. The established limit should be different for each system based on ability to pay. One method of doing this would be to establish a limit that would be shared by the state and LEAs. State and local shares could be based on those now determined by the BEP for funding education: 75 percent would be the state's share and 25 percent would be the LEA's share. Also, as in the BEP, the actual shares would be adjusted according to ability to pay. (See page 20.)

Response: The Department indicates that it will work with the General Assembly, the Department of Finance and Administration, and the State Board, as requested, to review funding for special education. (See page 86.)

The State Board of Education recognizes that "the Board has the statutory responsibility to develop a funding formula for excess costs." They indicate that this issue will be addressed by the Board during the current fiscal year. (See page 85.)

Data Collection

Both federal and state funding for special education depend on the collection of accurate data regarding the number of children receiving special education services and the types of services they receive. However, analysis of data collected from 1992 through 1995 indicates that some Tennessee school systems have received special education funds through the BEP for primary counts that exceed the number of children identified as having disabilities anytime during the year.

The Tennessee Department of Education contracts with a private firm, D&A Systems, for the collection and reporting of special education data. There are some indications that the current data may not be checked adequately, which could result in children being served for whom funding is not provided or systems receiving funding for which they are not providing services. (See pages 21-22.)

Recommendation: The data collection process should include internal procedures for ensuring validation of data and certification of the software used to prepare required reports. The validity of this data is important since it is used to determine eligibility for both state and federal funding. The accuracy of the data also must be assured in order to determine how or whether Tennessee's method for funding special education needs revision. (See page 22.)

Response: The Department concurs with the recommendation. See the response to "Trends" above. (See page 86.)

Least Restrictive Environment / Inclusion

Inclusion—which refers to including special education students in regular classrooms—and the extent to which it should be and can be employed in schools is a hotly debated issue. A national debate continues regarding whether schools should institute "full" inclusion—where all children are educated in regular classrooms—or whether schools should continue to provide separate alternatives for some special education students. Related issues include funding methods, labeling of students, assistive technology, and whether special education students' scores are included in state standardized testing. Some systems in Tennessee have included special education students in regular classrooms to a greater extent than others. (See pages 23-26.)

Recommendations: The State Board of Education and the Department of Education may wish to consider working with special education constituency groups to provide a comprehensive special education inclusion policy. In addition, the Board and the Department may wish to showcase successful inclusion projects to encourage similar successes in other systems.

In addition, the board and the department should step up efforts to provide staff development regarding inclusion, particularly for regular education teachers. Currently, such training exists, but is not required and serves only a small number of teachers. Training regular education and special education teachers to work together could allow more disabled students to be educated in regular classrooms. At the very least, increasing efforts to allow more students to be served in regular classrooms moves closer to fulfilling the federal mandate to educate all children in the least restrictive environment. (See page 27.)

Response: While the Department concurs with the recommendation under inclusion, it also adds information regarding its efforts toward encouraging inclusive education in schools throughout the state. According to the Department, "[i]n task force meetings we discussed developing a definition and/or policy for inclusive education. The members of the task force decided that since ***inclusion is not a federal mandate,*** *but is a part of the continuum of services when serving children in the least restrictive environment (LRE), the federal regulations for LRE would be sufficient to use as guidelines at this time." The Department has undertaken many activities and training events aimed at ensuring that "young children with disabilities are educated in natural environments." (See page 86.)*

Assistive Technology

Some school systems in Tennessee have used assistive technology to move special education students into regular classrooms. *Tennessee Code Annotated* §49-10-103(c)(2) requires that: "Impediments to learning and to the normal functioning of children with disabilities in the regular school environment shall be overcome by the provision of special aids and services rather than by separate schooling for the disabled." Assistive technology can help disabled students work more independently in a regular classroom setting, thus fulfilling the federal mandate to educate students in the least restrictive environment. In certain cases, assistive technology may assist in reducing students' needs for other school services. (See page 28.)

Recommendation: The Department of Education and the State Board of Education should explore the use of increased assistive technology for disabled students in Tennessee schools. Successful uses of assistive technology should be showcased to all systems, and should emphasize cases that have resulted in students' being able to learn in less restrictive environments. (See page 29.)

Response: The Department concurs with the recommendation and provides further information on its efforts to promote the use of assistive technology. (See page 89.)

Health Care Procedures in Schools

Some students in Tennessee schools have health care needs and require certain procedures, such as catheterization or the administration of medicines, in order to attend school. Those students with such needs include both regular and special education students.

Tennessee recently passed legislation for providing health care services in schools that is more restrictive than that in many other states and is more restrictive than guidelines adopted by the National Council of State Boards of Nursing and the Tennessee Board of Nursing. According to a recent Attorney General's opinion, the new legislation supersedes a policy previously adopted by the Tennessee Board of Nursing that would have allowed nurses to train and delegate certain health care tasks to unlicensed personnel in schools.

A survey conducted by OEA indicated that 131 nurses, both full- and part-time, were working in 117 of the 139 school systems in Tennessee during 1994-95. (See pages 30-42.)

The report contains several recommendations regarding the delivery of health care services in schools. (See pages 42-43.)

Recommendations: The General Assembly may wish to reconsider authorizing local education agencies to permit unlicensed persons to assist in providing some health care procedures to students in Tennessee schools. The Board of Nursing adopted a temporary policy to allow delegation to unlicensed personnel in the school setting, which should be followed for a period of time to determine its effectiveness. Using unlicensed personnel is prevalent in many states and was policy in Tennessee until recently. Some school systems may be hindered from hiring or contracting with a sufficient number of nurses for reasons beyond their control.

The General Assembly may want to amend the law to allow occupational and physical therapy services to be delegated as they had been previously.

The Department of Education, the State Board of Education, and the Department of Health should work together to develop comprehensive guidelines for the delivery of health care procedures in Tennessee's schools. This process should include input from the appropriate health related boards and school nurse organizations and associations, as well as teachers, school administrators, other school personnel, and parents and students.

School systems should consider entering into inter-district contracts for nursing services, if such agreements would be both feasible and economically beneficial. *Tennessee Code Annotated* §49-10-107 provides that school systems may contract with other systems for "educational, corrective or supporting services for children with disabilities."

If legislation is amended to allow schools to use unlicensed personnel with proper training and supervision, there are many possible alternatives that could reduce costs for school

systems. Depending on their resources, school systems could provide training for volunteers, allow senior year nursing students to train in schools, and even pay for licensed practical nursing training for new hires with a minimum length of employment stipulated. (See pages 42-43.)

Response: The Department generally concurs with the recommendations. As necessary, the Department indicates that it will work with other state agencies to develop guidelines for medical service delivery and health care in schools. The Department also indicates that such guidelines have been recently developed to describe the provision of health care procedures, including administration of medicine and the self-administration of medicine in public and private schools. Representatives of the board of nursing, the school health nurse organization, teachers, school administrators, and the departments of health and education participated. (See page 90.)

Discipline

Discipline appears to be the most controversial issue surrounding the reauthorization of the IDEA. While regular education students have certain due process rights with regard to suspension and expulsion, federal law mandates more extensive rights for special education students. Some see the current approach to discipline for special education students as preferential treatment because it sometimes appears that disabled students receive lesser punishments than nondisabled students for the same violation. However, the procedural safeguards were incorporated into the law to prevent discriminatory practices against the disabled. (See pages 44-50.)

Recommendation: Although most of the procedures regarding the disciplining of special education students are federally mandated, and do not allow the state much discretion, the State Board of Education should continue to work with educators to develop a range of options for placing disruptive youth and to address discipline of special education students. Further, the State Department of Education should implement the new policies by creating and distributing appropriate procedures, and by training school officials regarding the procedures. (See page 50.)

Response: The Department concurs with the recommendation. (See page 91.)

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Background

Introduction

Special education is a highly complex field, every aspect of which is affected by federal and state legislation, accompanying rules and regulations, and court decisions. Numerous concerns have been expressed about special education ever since passage of Public Law 94-142 in 1975, the major piece of federal legislation governing the education of children with disabilities. Lawmakers, educators, school administrators, parents, and disabled students often have conflicting views about the value of special education and about whether its goals are being accomplished:

> to assure that all children with disabilities have available to them...a free appropriate public education which emphasizes special education and related services designed to meet their unique needs, to assure that the rights of children with disabilities and their parents or guardians are protected, to assist States and localities to provide for the education of all children with disabilities, and to assess and assure the effectiveness of efforts to educate children with disabilities.[1]

This report examines a few of the many issues encompassed by special education: trends, funding and funding methods, data collection, inclusion, assistive technology, health care in schools, and discipline.

Federal Law

In looking at special education issues, it is important to have a basic understanding of the federal legislation that directs the delivery of educational services to disabled children. There are two principal federal laws that protect the educational rights of children with disabilities: Public Law 94-142, also called the Individuals with Disabilities Education Act or IDEA, and Section 504 of the Vocational Rehabilitation Act of 1973.

In 1975, Congress passed Public Law 94-142, then titled the Education for the Handicapped Act, firmly establishing the federal government's role in mandating education for children with disabilities. P.L. 94-142 was reauthorized in 1990 and was retitled the Individuals with Disabilities Education Act (IDEA). During 1995 it was again in the process of reauthorization in Congress, and, as of the printing of this report, had not been finalized. The law is based on the following basic premises:

- All children must receive a free and appropriate education without cost to their parents and regardless of the severity or type of disability.
- Procedural safeguards, including due process rights, must be ensured for all children with disabilities.
- Education in the least restrictive environment must be provided. To the maximum extent possible, students with disabilities must be educated with children who are not disabled.
- Individualized educational programming in the form of an individualized education plan (IEP) must be developed for each student receiving services under P.L. 94-142.

[1] 20 *U. S. Code* §1400.

> These written plans must be developed by a multi-disciplinary team (M-team) composed of at least the child's teacher, parent(s) or guardian(s), a representative of the local school district, and the student, when appropriate.

P.L. 94-142 defines the term "children with disabilities" to mean children with mental retardation, hearing impairments including deafness, speech or language impairments, visual impairments including blindness, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities.[2]

The regulations supporting the IDEA are contained in 34 Code of Federal Regulations, Part 300. Among other things, the regulations more thoroughly define the concepts contained in the IDEA (e.g., free appropriate public education, least restrictive environment, individualized education programs, due process, disabling conditions, and others), describe the states' and local educational agencies' responsibilities, and describe the method of allocating federal funds under the IDEA.

Section 504 of the Vocational Rehabilitation Act of 1973 contains many of the same provisions as P.L. 94-142—disabled students have the right to a free appropriate public education in the least restrictive environment and have due process rights to protect them from discrimination.[3] In the educational setting, it protects all students with disabilities whether or not they are categorized as special education students. Section 504 is much broader than IDEA and contains no categorical listing of disabling conditions. Unlike P.L. 94-142, Section 504 contains no funding provisions.

State Law

Prior to the passage of P.L. 94-142 in 1975, several states, including Tennessee, passed laws providing education services for disabled students. The Tennessee General Assembly in 1972 passed Tennessee's Mandatory Education Law for Handicapped Children and Youth, *T.C.A.* §§49-2912 to 2959 (Chapter 839 of the Public Acts of 1972):

> It is the policy of this state to provide, and to require school districts to provide, as an integral part of free public education, special education services sufficient to meet the needs and maximize the capabilities of handicapped children.

The state law governing special education in Tennessee is now codified as *T.C.A.* Title 49, Chapter 10. Much of what is contained in Tennessee's law mirrors the major provisions of the IDEA. However, in addition to the federal definition of "children with disabilities," state law includes three other categories: intellectually gifted, developmentally delayed, and functionally delayed. Children in Tennessee schools who fit into these categories are provided special education services, but the state receives no federal funds for them.

Significant legislation, both federal and state, and a few of the many court decisions that have shaped special education over the last two decades are described in Appendix B.

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[2] 20 *U.S. Code* §1401.
[3] 29 *U.S.Code* §794.

Methodology

The conclusions reached and recommendations made in this report are based on the following:

- books and articles from professional journals, magazines, and newspapers.
- interviews with those knowledgeable in the field of special education, including staff of the Department of Education's Division of Special Education, special education administrators and staff in systems across the state, staff in other states' special education departments, and members of advocacy groups for the disabled.
- a review of federal and state legislation concerning special education.
- a review of case law concerning special education.
- a survey of school superintendents regarding health care delivery and discipline issues conducted by the Office of Education Accountability. (See Appendix C for a copy of the survey.)
- a review of the Tennessee State Plan for Fiscal Years 1995, 1996, 1997 submitted by the Department of Education to the United States Department of Education.
- testimony at Education Oversight meetings.

Current Issues of Concern in Special Education

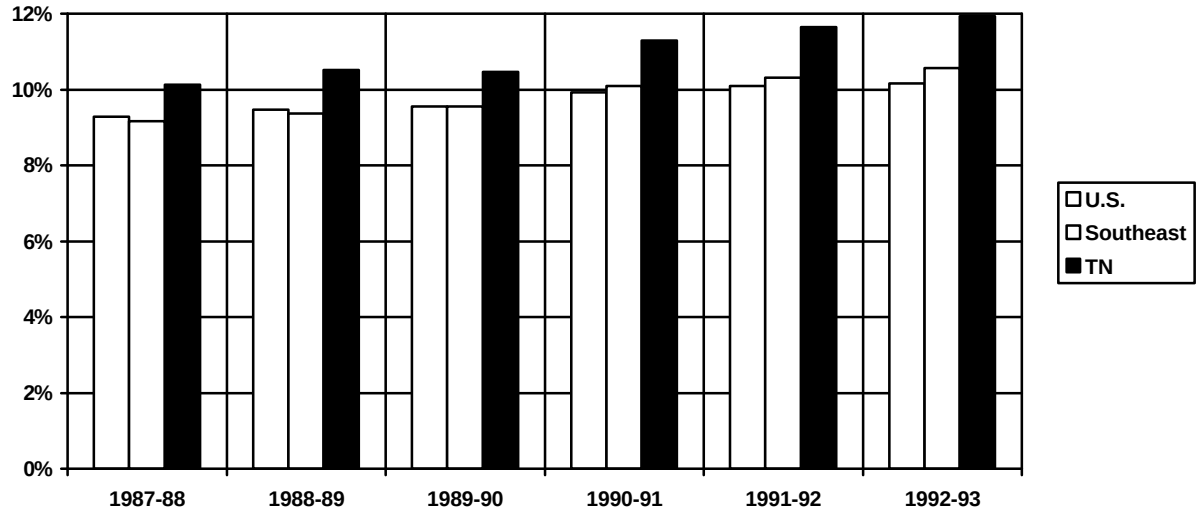
Trends

Key Points

- *The number of children in Tennessee being served by special education has increased at a rate much greater than that of the student population as a whole.*
- *The growth in the number of children identified as having disabilities is more than double the growth in average daily membership.*

As Exhibit 1 illustrates, Tennessee has served a higher percentage of children with disabilities than both the nation and the Southeast for each school year from 1987-88 to 1992-93 (the year for which the most recent federal data is available).

Exhibit 1
Percentage of Children Age 6-17 Served Under Chapter 1 of ESEA (SOP) and IDEA, Part B (Based on Resident Population)



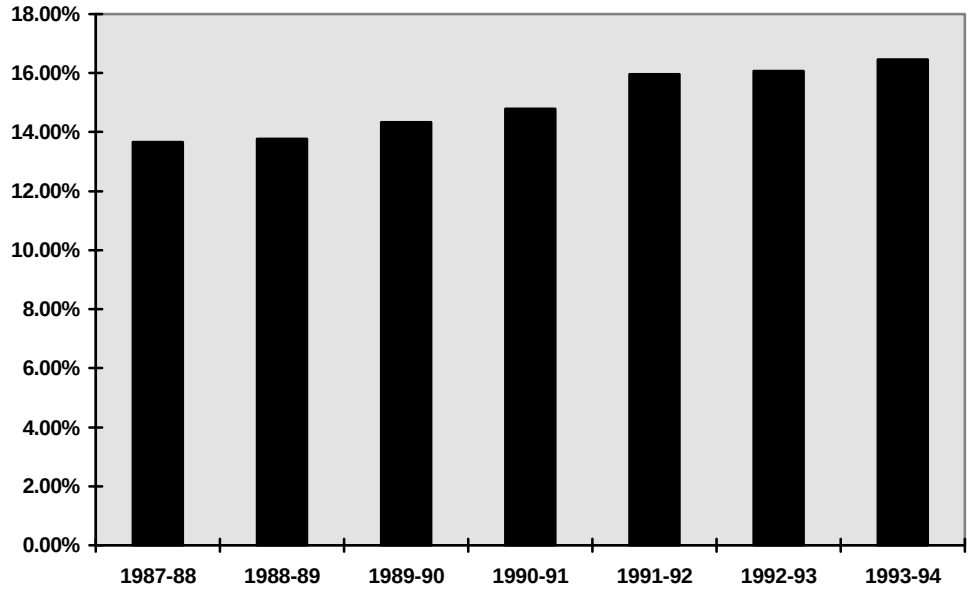
Source: Information collected from various Annual Reports to Congress on the Implementation of the Individuals with Disabilities Education Act, U.S. Dept. of Education. Note: The Southeast includes Tennessee, Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, and Virginia.

Exhibit 2
Percentage of Children Age 6-17 Served Under Chapter 1 of ESEA (SOP) and IDEA, Part B (Based on Resident Population)

	TN	AL	AR	FL	GA	KY	LA	MS	NC	SC	VA
1987-88	10.12%	10.38%	9.37%	10.00%	7.18%	9.50%	6.82%	9.46%	8.81%	10.21%	9.52%
1988-89	10.52%	11.12%	9.28%	10.45%	7.01%	9.48%	6.87%	9.64%	9.16%	10.27%	9.51%
1989-90	10.46%	11.03%	9.09%	10.85%	7.27%	9.73%	7.11%	9.82%	9.57%	10.33%	9.58%
1990-91	11.29%	11.41%	9.59%	11.44%	7.99%	9.98%	7.52%	10.28%	10.18%	10.82%	9.93%
1991-92	11.64%	11.59%	8.20%	11.81%	8.25%	10.04%	7.98%	10.51%	10.41%	10.96%	10.49%
1992-93	11.93%	11.60%	10.10%	11.76%	8.64%	9.91%	8.19%	10.81%	10.62%	10.94%	10.78%
1993-94	12.14%	11.89%	10.25%	12.21%	8.94%	9.66%	8.58%	10.84%	10.59%	10.94%	10.89%

Source: Annual Reports to Congress on the Implementation of the Individuals with Disabilities Education Act, U.S. Dept. of Education, 1989-1995.

Exhibit 3
Percentage of Children Receiving Special Education Services in Tennessee Federal Categories Only* (Based on Average Daily Membership)



Source: Annual Statistical Report, Tennessee Department of Education

* Note: These figures include only the federal categories. Tennessee also funds the following categories: intellectually gifted, functionally delayed, and developmentally delayed.

In the Southeast, as Exhibit 2 on page 5 indicates, Tennessee ranks either second or third for percentage of children served for each year except 1992-93; in that year it ranks first of the 11 states included.

Looking at the data another way—the percentage of children in Tennessee receiving special education services based on ADM during school years 1987-88 to 1993-94—supports the trend of increasing special education proportions in Tennessee. The percentage of children receiving special education services in Tennessee has increased by an average of 0.46 percent per year from 1987-88 to 1993-94, as shown in Exhibit 3 on page 5. (The percentages are considerably higher than those depicted in Exhibits 1 and 2 because those represent children ages 6-17, while Exhibit 3 includes children age 3 to 21.) By contrast, the percentage of children receiving special education services in the Southeast increased by an average of 0.29 per year from 1987-88 to 1993-94 and in the U.S. by an average of 0.18 percent per year for the same period.[4]

Exhibit 4 indicates that among Tennessee's school systems, the percentage of children reported to be receiving special education services over the past eight years varied widely—from a low of about seven percent in Smith County in 1988 to nearly 41 percent in Manchester in 1992.

Exhibit 4
Percentage of Children Receiving Special Education Services in Tennessee
All Tennessee Categories (Based on Average Daily Membership)

	State Total (%)	State Max. (%) (School District)	State Min. (%) (School District)
1987-88	15.88%	36.82% (Grundy Co.)	7.05% (Smith Co.)
1988-89	15.96%	39.65% (Sequatchie Co.)	7.30% (Smith Co.)
1989-90	16.70%	34.12% (Sequatchie Co.)	7.75% (Smith Co.)
1990-91	17.24%	33.27% (Hancock Co.)	8.57% (Smith Co.)
1991-92	18.57%	40.63% (Manchester)	9.24% (Smith Co.)
1992-93	19.15%	34.37% (Sequatchie Co.)	10.84% (Smith Co.)
1993-94	19.15%	33.76% (Sequatchie Co.)	11.23% (Union City)
1994-95	19.82%	34.40% (Etowah)	11.25% (Oneida)

Source: Department of Education, Annual Statistical Reports, Tables 7A and 11

[4] It should be noted here that we are using two different sets of data, one provided within the Tennessee Department of Education's *Annual Statistical Report*, which includes children age 3 to 21, and the other provided within the *Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act*, U.S. Department of Education, 1995, which represents children ages 6-17. The data are not directly comparable. The purpose of these charts is to demonstrate that the percentage of children receiving special education services in Tennessee is increasing by both measures. If net enrollment were used for comparison, these percentages would be slightly lower.

Exhibit 5 shows the change in disability categories of children served by special education in Tennessee from 1991-92 to 1994-95. Although much national attention has been focused on the increase in the learning disabled category, because it is the largest, the data indicates that other categories have experienced much larger average annual percentage increases for the period examined: health impaired (31.64%); traumatic brain injury (28.84%); autism (21.21%); language impaired (15.11%); other developmentally delayed (14.27%); and blind (14%). (See Appendix D for definitions of each disability category.)

Exhibit 5
Number of Children with Disabilities Receiving Special Education Services in Tennessee
(Table 11 ASR)

School Year	1991-92	1992-93	1993-94	1994-95	Average Annual Change
Learning Disabled	66,541	67,837	68,584	70,684	2.03%
Speech Impaired	28,463	26,877	26,522	26,378	-2.50%
Mentally Retarded	14,782	14,446	15,792	16,542	3.82%
Gifted*	17,905	18,624	18,539	19,019	2.03%
Language Impaired	8,873	11,201	12,242	13,533	15.11%
Health Impaired	3,796	4,940	6,521	8,659	31.64%
Emotionally Disturbed	3,088	3,400	3,812	4,080	9.73%
Other Functionally Retarded*+	2,518	2,469	2,855	3,328	9.74%
Multihandicapped+	1,892	2,023	2,078	2,140	4.19%
Physically Impaired	1,575	1,583	1,728	1,785	4.26%
Hearing Impaired	1,525	1,156	1,186	1,199	-7.70%
Other Developmentally Delayed*+	1,093	1,331	1,547	1,631	14.27%
Visually Impaired	771	658	682	839	2.86%
Autism	310	410	513	552	21.21%
Deaf	202	229	201	206	0.66%
Blind	162	249	248	240	14.00%
Traumatic Brain Injury	108	126	185	231	28.84%
Deaf/Blind+	30	15	47	22	-9.82%
Total	**153,634**	**157,574**	**163,282**	**171,068**	**3.65%**

Source: Department of Education Annual Statistical Report
* non-federal category
+ Multihandicapped was renamed Multidisabled in 1993-94. In 1993-94, Other Functionally Retarded was changed to Functionally Delayed, and Other Developmentally delayed to Developmentally Delayed.

Exhibit 6 indicates that the growth in children identified as having disabilities (from Table 11 of the Department of Education's Annual Statistical Report) is more than double the growth in average daily membership. The table displays the change in ADM, the change in the number of children receiving special education, and the change in the number of children served by options from 1991-92 to 1994-95. Although the growth in options served appears to be considerably greater than the growth in children with disabilities, this disparity may be partially explained by the increase in the number of children receiving services under secondary options.

The figures for the number of children receiving special education services are taken from Table 11 of the Department of Education's Annual Statistical Report, which represents a cumulative count—that is, one child may be counted several times if he or she has been served by more than one school system during the school year. This could explain why the average growth in children with disabilities (3.65%) is more than twice the growth in average daily membership (1.52%). However, the number of children served by primary options—data that was provided by the Division of Special Education—indicates even greater growth for the same period (3.83%).

Exhibit 6
Average Daily Membership
and counts related to Children
With Disabilities 1991-92 to 1994-95

Year	ADM	Children w/ disabilities served (Table 11- ASR)	Primary Options	Secondary Options	Total Options
1991-92	827,525	153,634	128,919	20,793	149,712
1992-93	841,098	157,574	132,971	22,566	155,537
1993-94	851,903	163,282	137,476	23,907	161,383
1994-95	865,925	171,068	144,307	25,267	169,574
Average Growth	1.52%	3.65%	3.83%	6.71%	4.24%

Source: Department of Education Annual Statistical Reports and February Special Education Census for 1991-92, 1992-93, and 1993-94; preliminary data provided by the Department of Education for 1994-95.

Recommendation: The Department of Education and the State Board of Education should analyze special education data periodically to determine the extent to which actual variations exist, the consistency in data procedures, and the appropriate course of action to take where numbers of special education students significantly increase or decrease. Funding and services are dependent on accurate counts of children from all systems.

Funding and Funding Methods

Key Points

The type of funding formula used to generate special education funds can affect the number and type of children served, the programs and services provided by local districts, the amount of time students spend in special education programs, placement of students in various programs, class size, and caseloads.[5] *Ongoing debate continues over the best funding method to use to avoid over- or under-identification of special education students.*

- *The method used by the federal government to distribute funds to states for special education—essentially, the same amount is generated per special education student regardless of disability—has been criticized for creating an incentive for states to classify more students as special education to increase the amount of federal funding.*
- *Tennessee's method—which generates money based on the services each child receives—has been said to create an incentive for local education agencies to place special education children in more restrictive options in order to generate more state funding.*
- *The National Association of State Boards of Education suggests using a formula based on the national average of individuals with disabilities. This would alleviate under- or over-identification, since funding would not be based on actual counts of children with disabilities.*

The IDEA has never been fully funded by the federal government. In 1975, Congress authorized appropriations to reach the maximum level of 40 percent of the excess costs of special education by 1982. However, that amount has never been appropriated—as of fiscal year 1995, Congress appropriated approximately eight percent of the excess costs related to special education.[6]

In addition, the federal method for distributing special education funds has been criticized. Essentially, federal funds for special education are distributed to states based on the total number of children receiving special education and related services. The National Council on Disability suggests that allocation of federal funds should be based on a weighted presumed incidence model rather than on the current child count. They argue that the current system encourages school districts to label children to receive increased funding. According to the Council, a presumed incidence model would allocate funds based on the expected percentage of students with disabilities in the states, removing the incentive to

[5] Fran O'Reilly, *State Special Education Finance Systems, 1992-93*, Center for Special Education Finance, December 1993, pp. 26, 29.

[6] National Council on Disability, *Improving the Implementation of the Individuals with Disabilities Education Act: Making Schools Work for All of America's Children*, May 9, 1995, Washington, D.C., p. 164. 20 *United States Code* 1414(a)(i) provides that federal funds are to be used to pay only the *excess costs* directly attributable to the education of children with disabilities. This prevents an LEA from using funds provided under Part B to pay for *all* of the costs for educating disabled children with federal money.

label. In addition, the model could be weighted to allow for variables such as high rates of poverty, as are other government funding programs.[7]

There is also concern about how states, including Tennessee, distribute funds for special education. According to the Center for Special Education Finance, more than half of the states are currently considering major reform of their special education programs, including their funding formulas. A primary reason for reform appears to be that: "Reducing the number of restrictive special education placements in school districts has become a clearly articulated federal policy objective."[8]

How Special Education is Funded in Tennessee

In 1993-94, the most recent year for which state data is available, Tennessee spent a total of $277,738,307 on special education, according to the Department of Education's *Annual Statistical Report*. Of this, $52,919,550, or 19 percent, was provided through federal funding; the remainder, $224,818,757, or 81 percent, was provided through state and local funding.

Federal funding

One major federal program provides states with financial assistance to educate disabled students: the Part B State Grant Program. Tennessee's 1995-96 federal grant under IDEA totaled $51,642,649. Two other formula grant programs are authorized under IDEA: the Part H Program for Infants and Toddlers with Disabilities and the Part B, Section 619 Preschool Grant Program. Tennessee's 1995-96 federal grant for preschool totaled $6,706,475.

Part B State Grant Program and Preschool Grant Program

	Preschool	IDEA
1992-93	$6,851,370	$44,210,780
1993-94	$6,728,325	$46,191,225
1994-95	$6,850,269	$47,732,785
1995-96	$6,706,475	$51,642,649

Source: Division of Special Education, Department of Education

(See Appendix E for a more detailed discussion of how federal funding is generated for special education.)

State Funding

The state's portion of funding for education is generated through Tennessee's Basic Education Program (BEP). In general terms, the BEP provides for the allocation of funds to each local school system based on the costs of 42 components determined by the State Board of Education to be needed by all local systems. The 42 components of the BEP are divided into two categories, classroom and non-classroom components. The state funds 75 percent of the cost of classroom components and 50 percent of the cost of non-classroom components.

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[7] Ibid, p. 167.

[8] Thomas B. Parrish, "What is Fair? Special Education and Finance Equity," *CSEF Brief* No. 6, Fall 1995, p. 5.

Local education agencies have a great deal of discretion as to how to spend the funds that the BEP generates. In other words, even though some of the components specifically generate funds for special education—including salaries for teachers, assistants, supervisors, and assessment personnel, as well as monies for materials and supplies, instructional equipment, and classroom travel—the funds generated may be spent in any area of education that the LEA deems necessary.

Children eligible for special education are funded in the same manner as other children for the purposes of entitlement to academic program funds from Tennessee's BEP. Additional state funds generated for special education are determined by the number of special education students identified and served as receiving various options of service as presented in the BEP funding formula. On February 1 each year, the Tennessee Department of Education collects a census of children being served in options 1-10 (described below). BEP funds for the following year are based on that census.

The BEP funds generated for the salaries of special education teachers are related to the level of service provided to special education students. Tennessee's special education students are categorized within "options" based on the services they need. The services are determined by each student's multi-disciplinary team and are recorded in each student's Individualized Education Plan (IEP). Students may be placed in both a primary and secondary option, depending on the services they need. The table below contains the description for each option of service and the hours of service students receive in each option.

Descriptions of options and corresponding hours of service

Option	Description	Contact Hours
Option 1	a. Consulting Teacher b. Direct Services c. Related Services	a. Consults with regular teacher at least twice a month b. Less than one hour per week c. At least twice a month and less than one hour per week (three times a year OT/PT)
Option 2	Direct Instructional Services	1-3 hours per week
Option 3	Resource Program	4-8 hours per week
Option 4	Resource Program	9-13 hours per week
Option 5	Resource Program	14-22 hours per week
Option 6	Ancillary Person	4 hours per day in the regular classroom
Option 7	Development Class / Mainstreamed	23 or more hours per week
Option 8	Self-contained Comprehensive Development Class	32.5 or more hours per week including 2 related services
Option 9	Residential Program	24 hours per day
Option 10	Homebound/ Hospital Instruction	3 hours per week

Source: Division of Special Education, Department of Education

For each option, the caseload allocation has been determined, i.e., the number of children necessary to fund one teacher, as the table below indicates.

Options and Caseload Allocations

Option	Caseload Allocation
Option 1	91
Option 2	73
Option 3	46
Option 4	25
Option 5	15
Option 6	2
Option 7	10
Option 8	6
Option 9	0[9]
Option 10	10

Source: State Board of Education BEP booklet

In addition to providing teachers' salaries, insurance, and benefits, the BEP generates funds supplying:

- one special education assistant for every 60 special education students identified and served in options 5, 7, and 8.
- one special education supervisor for every 750 special education students identified and served.
- one special education assessment personnel for every 600 special education students identified and served.
- classroom materials and supplies per special education student identified and served.
- instructional equipment per special education student identified and served.
- classroom related travel per special education student identified and served.

In 1995-96, the BEP generated approximately $1,600 for each child identified and served as special education (primary option only). Approximately $1,200 of this would have been state funds if the BEP had been fully funded.

[9] The caseload allocation for option 9 is 0 because children receiving services in this option are in residential programs. The Department has expressed concern about this, stating that before the BEP this option was the highest weighted option and generated the most dollars. Systems must pay high costs for these placements and "additional funds" provided are never more than 60 percent of the cost for these services. During 1995-96, the Department indicates that they received only 50 percent of the cost.

Basic Education Plan funding for special education
1995-96

	# of Personnel	Amount
Special Education Teachers	6,083.0	$152,814,680
Special Education Supervisors	223.5	5,611,694
Special Education Assessment Personnel	283.0	7,105,855
Special Education Assistants	607.5	7,290,000
Benefits		39,593,153
Classroom Materials and Supplies		3,561,054
Instructional Equipment		1,865,314
Classroom Related Travel		1,187,018
Cost Differential Factor		11,899,733
Total	**7,197.0**	**$230,928,501**
Special Education identified & served (Primary only)		144,307
BEP revenue per identified & served		$1,600
State share (75%)		$1,200

Extracted from 1995-96 BEP estimates approved 10/3/95

BEP funding is based on the number of special education children identified and served within the various options of service. For years 1992-93 to 1995-96, funding has been based on the number of students in the primary and secondary options as reported in the February census. Commencing in 1995-96, the Department of Education intends to collect these counts nine times a year and base the BEP entitlement on the weighted average of children identified and served by option for the year. (See also the section titled "Data Collection.")[10]

Excess cost funding

The state also provides local education agencies with additional funds for special education students with high cost IEP requirements. School systems can apply to the state Department of Education to be reimbursed for very high cost children. The reimbursement comes from 15 percent of the total federal monies the department receives under the IDEA, which it retains for other purposes including assistance to LEAs for high cost children.

Reimbursement, under the current method, is dependent on what "priority" category students fall under. Priority 1 students are those placed by a state agency (such as the Departments of Human Services, Mental Health and Mental Retardation, Youth

[10] Although BEP funds for special education have been based on the February 1 count, *T.C.A.* §49-3-351(d) actually requires that the BEP should be calculated on the "basis of prior year average daily membership (ADM), or full-time equivalent average daily membership (FTEADM), or identified and served special education (I&S)." Beginning with the 1995-96 change in data collection, the Department will fulfill this directive.

Development, or Health) in a school system other than the one they would normally attend. Priority 2 students attend a State Department of Education Special School, such as Tennessee School for the Blind, Tennessee School for the Deaf, and West Tennessee School for the Deaf. LEAs with Priority 2 students who require additional expenditures are reimbursed 100 percent of the excess cost for both priorities 1 and 2.

Priority 3 students are very high cost children who are the responsibility of the LEA. A student is considered "very high cost" when the excess cost of educating the child is 150 percent greater than the total funds available for the child. Reimbursement for such children may be only 60 percent or less of the excess cost. School systems are allowed a maximum of .5 percent of the February 1 census count for total number of students served in the primary options. If a system has less than 600 students, they will be allowed to submit up to three high cost students for Priority 3.

Tennessee Code Annotated §49-1-302(h) directs the State Board of Education to establish a limit on local costs on special education and provide for state assumption of costs in excess of this limit. However, the law contains no deadline for meeting this requirement, and, to date, no method has been established. The current method employed by the Division of Special Education only partially meets this mandate, since for children ranked as "Priority 3" LEAs may be reimbursed only 60 percent or less of the excess cost. The percentage of Priority 3 excess cost requirements funded is as follows:

Excess Cost Reimbursed to Priority 3 Requests

1992-93	60%
1993-94	34%
1994-95	55%
1995-96	to be determined

Source: Division of Special Education, Department of Education

The Division of Special Education bases the excess cost reimbursement eligibility on the caseload allocation for each option. To determine the amount of funds generated for an eligible child in each option, the caseload allocation is divided into the state portion of the average instructional salary for teachers—which was $17,505 in 1994-95. For example, $17,505 divided by 91 (the caseload allocation for Option 1) = $192; therefore, $192 in state funds is generated for each eligible child served under Option 1. The resulting amount can then be multiplied by the number of children in each option in each local education agency to determine the total amount of state funds generated for an eligible child. This methodology produced the following amounts to be used to determine eligibility for excess cost funds distributed by the state for 1995-96. The Department of Education has indicated that beginning with the 1996-97 school year eligibility for excess cost will be based on systems' prior years' actual expenditures.

Amounts used to determine eligibility for excess cost funds distributed by the state for 1995-96

Option	Caseload Allocation	Amount of State Funds Generated for an Eligible Child
Option 1	91	$192
Option 2	73	$240
Option 3	46	$381
Option 4	25	$700
Option 5	15	$1167
Option 6	2	$8752
Option 7	10	$1751
Option 8	6	$2918
Option 9	0	$----
Option 10	10	$1751

Source: Division of Special Education, Department of Education

Under the current system, a child with special education expenses of $200,000 could result in the typical LEA being required to contribute more than $130,000 (based on the amount reimbursed for the 1993-94 school year). In several small rural systems, this could result in decreased availability of funds exceeding $100 for every student enrolled in the system (three percent of the per pupil expenditure). The system would either have to increase taxes or lower its per pupil expenditure by $100 per student.

Criticisms of Tennessee's Funding Method

Tennessee distributes special education funds to school systems based on options of services. Under this system, the more restrictive a student's placement, the more BEP funds are generated. This type of system, critics argue, encourages placing students in more restrictive environments—counter to the IDEA's least restrictive environment provision—to generate more state dollars.[11] The funding mechanism for special education in Tennessee has been reviewed by both the State Board of Education and the Department of Education for the past two years but no changes have been made.

Previous funding formula—In 1983-84, the Tennessee funding formula for special education was changed from a "flat" formula to a "weighted" formula under the Tennessee Foundation Program (TFP). Under the flat formula system, state money had been distributed to local education agencies based on the total number of children served under special education, and not according to the type of disability or services provided—basically, the same method the federal government uses. In 1993, the results of a longitudinal study published in *Exceptional Children* indicated that following the change to a weighted system, there was an increase in more restrictive placements in Tennessee schools. Samuel Dempsey and Douglas Fuchs of the George Peabody College of Vanderbilt University analyzed the numbers of children placed in various service options from 1978-80 to 1987-88. "Overall, results indicate a shift in placement from lower

[11] Parrish, p.5.

funded (less expensive) to higher funded (more costly) service options concurrent with the change from a flat to a weighted reimbursement formula."[12] This study has been cited as evidence that Tennessee's funding formula encourages placement in a more restrictive environment. However, the study is based on data that preceded implementation of the BEP.

Present funding formula—Analysis of data since inception of the BEP does not indicate a similar shift from less expensive to more expensive options. Rather, the increases in options follow no obvious pattern. The table below contains the average annual percent change in options for both primary and secondary placements from 1992-95. Students are assigned a primary option based on their most significant disability. They also may be assigned a secondary option if they have other less critical disabilities that require special education services.

BEP Options 1 - 10 /
Average Annual Change 1992-95

	Primary	Secondary
Option 1	10%	13%
Option 2	1%	4%
Option 3	4%	-8%
Option 4	5%	-15%
Option 5	6%	11%
Option 6	11%	
Option 7	0%	
Option 8	1%	
Option 9	15%	
Option 10	4%	
Overall	4%	7%

Source: Division of Special Education, Department of Education February Census data 1992 to 1995

Analysis of the February census counts for the years 1992-95 used in the BEP indicates that the greatest growth is reported for children receiving special education services in service options 1, 6, and 9. Although option 6 is the most expensive option, option 1 is the least costly. Growth in these options is 11 percent and 10 percent respectively. Service option 9, a residential program, indicates the highest rate of growth—15 percent—but generates little in funding under the BEP. (See page 11 for a description of service

[12] Samuel Dempsey and Douglas Fuchs, "'Flat' Versus 'Weighted' Reimbursement Formulas: A Longitudinal Analysis of Statewide Special Education Funding Practices," *Exceptional Children*, Vol. 59, No. 5, pp. 433-443.

options.) Based on this information, it is difficult to state definitively that the current funding system has resulted in a greater number of placements in more expensive options.

Approaches to Special Education Funding

The type of funding formula used by a state can affect the number and type of children served, the programs and services provided by local school districts, the amount of time students spend in special education programs, placement of students in various programs, class size, and caseloads.[13] The Center for Special Education Funding (CSEF) has identified six basic formula types used by states to distribute special education funds:

1. ***Unit formulas*** provide a fixed amount of money for each qualified unit of instruction, administration, and/or transportation. Funding is disbursed for the cost of the resources needed to operate the unit, such as salaries for teachers and aides. The amount of funding provided may vary by type of unit. Regulations typically define pupil-teacher ratios or class size and caseload standards, either by disability or by type of placement (e.g., resource room). For example, the state may fund one staff unit for each five students with severe disabilities and one staff unit for each 45 students with a speech impairment.
2. ***Personnel formulas*** provide funding for all or a portion of the salaries of personnel working with children with disabilities. No other costs are reimbursed. As such, personnel formulas can be viewed as a special case of the unit formula, where funding is provided only for personnel costs. The percentage reimbursement may vary by personnel type. For example, the salaries of certified teachers may be reimbursed at a rate of 70 percent while salaries for aides may be reimbursed at a rate of only 30 percent. Pupil-teacher ratios are typical of this formula type and minimum state salary schedules are often included as well.
3. ***Weighted formulas*** provide funds for each child with disabilities as a multiple of the general education per pupil reimbursement. This formula is essentially a per pupil funding mechanism, with different amounts provided based on a pupil's disability and/or placement.
4. ***Straight sum or flat grant formulas*** provide a fixed amount of money for each eligible student with disabilities. The amount may or may not vary by disability of the students served. A cap on the percentage or number of students for whom reimbursement will be provided may be applied to control costs.
5. ***Percentage-based formulas*** provide to school districts a portion of approved costs of special education services. The percentage approach can be combined with other formula types, such as personnel, to provide districts with a percentage of special education teacher salaries. Reimbursable costs usually must be in approved categories and cost ceilings may apply.
6. ***Excess cost formulas*** are used to reimburse school districts for all or part of the costs of educating children with disabilities that are over and above the cost of the regular education program.[14]

Researchers tend to group the six formula types according to the main factor used for allocating funds: resources, students, or costs. Resource-based formulas include unit and personnel mechanisms in which distribution of funds is based on payment for specified resources, such as teachers, aides, and equipment. (Tennessee's method of funding comes closest to this type.) Student-based formulas include the weighted and flat grant formulas and are based on the number and type of children served. Cost-based formulas include the percentage and excess cost methods, which are based on district expenditures for special education services.[15]

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[13] O'Reilly, pp. 26, 29.
[14] Ibid, pp. 12-16.
[15] Ibid, p. 17.

According to CSEF, in 1992-93 the most common approach to funding special education programs was pupil weighting followed by cost-based formulas. Most of the states that have revised their formulas in the last several years had been using flat grant formulas, but the formulas to which they changed do not reflect an overall trend.

The National Association of State Boards of Education (NASBE) suggests that one way of revising current methods would be to use a formula that is based on the national average of individuals with disabilities. They suggest using a formula similar to the following:

total amount awarded to district for special education = ADM x 12% X

(ADM = average daily membership; 12 = % of students with disabilities (national average); and X = the amount of state special education funding per student, figured from a set percentage of the general education formula)

For example, if districts are reimbursed $500 per general education student plus an additional 50 percent of that amount for each special education student, "X" would be $250. According to NASBE, because this method is not based on counting disabled students served, it encourages neither under- nor over-identification: "The idea is to encourage districts to 'average back to the center'— to align the percentages of students classified as having disabilities with the nationwide average." In addition, the model assumes that districts are allowed to use their funds flexibly, and that a poverty factor would be built into the formula, since research indicates that there are generally higher percentages of students with disabilities in high poverty areas.[16]

Other States' Funding Methods

Since 1982, several states have revised their special education formulas. Oregon, for example, reacting to a statewide measure that limits property taxes and requires the state to pay a greater share of public education, completely revised its method of distributing special education funds. (Local property taxes had previously funded 80 percent of the total resources to support public schools in Oregon.) The state now grants districts two times the regular per student allocation for every identified special education student, up to a cap of 11 percent of ADM. Most national studies show that the education costs for an average special education student are about twice that of a general education student. Therefore, Oregon's state aid for special education students is determined by simply doubling its general education allocation.[17] In addition, because the monies provided Oregon's school districts for both regular and special education are no longer distinguished as separate funds, special education funds are not required to be used only for students with disabilities.[18]

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[16] National Association of State Boards of Education Study Group on Special Education, *Winners All: A Call for Inclusive Schools,* October 1992, p. 32.

[17] Parrish, p. 6.

[18] Thomas B. Parrish and Deborah L. Montgomery, *The Politics of Special Education Finance Reform in Three States,* Center for Special Education Finance, March 1995, p. 4.

Other states, notably Vermont, Pennsylvania, Massachusetts, and Montana, have revised their methods for funding special education to census-based funding. Basically, the amount of special education aid for each district is based on the overall count of students in the district, not on the total number of special education students they enroll.[19]

In 1990 Vermont passed a law radically changing its special education system and how it is funded. The state essentially merged special and general education, partly by instituting "instructional support teams" (ISTs), which all Vermont schools must provide for teachers who might otherwise immediately seek special education services for students.[20] Vermont's funding formula, now census-based, also allows districts to spend money on compensatory or remedial programs for all students who need them, not just special education students. Between 1989 and 1993, the number of students in special education fell by 18.4 percent. The downside is that the state's costs for special education have not decreased, although some speculate that they would have risen faster if the changes had not been made.[21] In fact, the state share of special education costs, which was to have been 50 percent, decreased to 44.8 percent in 1993-94. According to the American Education Finance Association, Vermont has a $4 million deficit in its FY 1995 special education budget.[22]

Pennsylvania, prior to its reforms which began in the 1991-92 school year, funded 100 percent of the excess cost of educating children with disabilities. In addition, the state provided special education services through regional service agencies, which served students whose districts did not provide their own programs. Its funding system treated these intermediate programs differently from school district programs in the way excess costs were funded: school districts received state funding only for excess costs, while the intermediate units received payment for the full cost of services. This fostered growth of the intermediate units as the principal providers of special education services. Like Vermont, the state implemented instructional support teams (ISTs) designed to intervene prior to special education evaluation. During 1990-91, the first year of its implementation, the schools using ISTs experienced a 48 percent reduction in special education placements compared to the previous year. By August 1991, the new funding formula was adopted, gradually reducing direct state support for the intermediate units and providing funding directly to districts based on the average daily membership of all students.[23]

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[19] Thomas B. Parrish, *The Future of Special Education Finance* (Draft), Center for Special Education Finance, May 16, 1995, pp. 8-9.

[20] Tennessee's Department of Education recommends but does not require that schools use the support team approach.

[21] Lynn Schnaiberg, "Pioneer System for Special Ed. Watched in Vermont," *Education Week*, Nov. 1, 1995, p. 16-17.

[22] Steven D. Gold, David M. Smith, Stephen B. Lawton, Compilers and Editors, *Public School Finance Programs of the United States and Canada, 1993-95, Volume Two,* American Education Finance Association, and Center for the Study of the States, The Nelson Rockefeller Institute of Government, Albany, New York, 1995, p. 613.

[23] Parrish and Montgomery, pp. 8-9.

Recommendations: OEA staff recommends that the Board and the Department consider using a formula for funding special education that is based on the national average of individuals with disabilities, such as NASBE advocates.

In addition, the State Board of Education should establish a limit on local costs for special education and provide for state assumption of costs in excess of this limit. The limit should be sufficiently high to provide an incentive for LEAs to apply cost controls while providing necessary services identified by students' multi-disciplinary teams and recorded in their IEPs. The established limit should be different for each system based on ability to pay. One method of doing this would be to establish a limit that would be shared by the state and LEAs. State and local shares could be based on those now determined by the BEP for funding education: 75 percent would be the state's share and 25 percent would be the LEA's share. Also, as in the BEP, the actual shares would be adjusted according to ability to pay.

For example, if the limit were established at $10,000, the typical LEA would be required to contribute $2,500 (25 percent) before the state assumed 100 percent of the costs. This $2,500 requirement would be greater for wealthy systems and lower for less affluent systems. This methodology would result in the state paying the excess cost of high cost special education students. Excess cost would be defined as all expenses in excess of the funds provided by the federal government and funds included in the BEP plus the local share of the established limit. The established limit could be adjusted each year for inflation as are other BEP components.

Data Collection

Key Points

- *The Tennessee Department of Education contracts with a private firm for the collection and reporting of special education data.*
- *There are some indications that the current data may not be checked adequately, which could result in children being served for whom funding is not provided or systems receiving funding for which they are not providing services.*

Both federal and state funding for special education depend on the collection of accurate data regarding the number of children receiving special education services and the type of services they receive. However, analysis of data collected from 1992 through 1995 indicates that some Tennessee school systems have received special education funds through the BEP for primary counts that exceed the number of children identified as having disabilities anytime during the year. Department officials claim that some school systems did not follow directions for providing data, but OEA analysis indicates that department procedures in this area are not adequate.

The Department of Education compiles special education data several times during the year, and contracts with a private firm, D&A Systems, for the collection and reporting of special education data. D & A Systems collects and reports special education data using software developed by the company owners. The Department has contracted with D&A since 1991-92. Department staff indicate that they will continue to contract for these services because the Student Management Information System packages certified and approved by the Department of Education do not include the automation of data requirements for special education.

For years prior to 1995-96, data was collected four times a year in October, December, February, and June. (See Appendix F for a brief description of the counts taken prior to the 1995-96 school year.) Each of these reports provided different data. While it is possible to measure trends from year to year, the data cannot be used to make direct comparisons during a single year. Beginning in 1995-96, D&A added a module that will allow LEAs to report ADMs of students receiving special education for the entire school year and any 20-day reporting period by school and by school system. In addition, LEAs will be required to submit special education census data in conjunction with the Superintendent's Annual Attendance report submitted to the Department of Education no later than June 30 of each year. The census data will be used to provide an average count of special education students by option for purposes of determining BEP funding.

Even though the various counts taken during a school year cannot be precisely compared, there should be a strong correlation among them. For example, the February 1994 census of children receiving various levels of service (primary option only) should roughly, although not exactly, correspond to the number of children with disabilities as reported in

the June count and Table 11 of the Annual Statistical Report. In most cases, the numbers reported in the 1994 ASR, which are taken from the cumulative June count, should be slightly higher than the February 1994 count; in no case should the number be lower. However, 1994 data indicates that two systems counted more children with disabilities in February—the count used to generate funds through the BEP—than were counted in the cumulative end-of-the-year count. Each of the years examined—1992 through 1995—indicated that some systems have received funds through the BEP for primary counts that exceed the number of children identified as having disabilities anytime during the year. According to the department, some systems may have purged their rolls prior to providing data for the cumulative June count, resulting in the appearance that more children were counted in February than were present throughout the entire school year.

In addition, various findings from the Department of Education's internal audit section indicate that special education students have not been classified correctly on the D&A census program. Auditors note that since the D&A report is used to compute BEP funding, these kinds of errors can result in a school system receiving too much or too little state education funding. Some audit findings indicate that option 7-9 children are sometimes counted differently in special education counts than they are in counts for the purpose of determining total ADM.

Recommendation: The data collection process should include internal procedures for ensuring validation of data and certification of the software used to prepare required reports. The validity of this data is important since it is used to determine eligibility for both state and federal funding. The accuracy of the data also must be assured in order to determine how or whether Tennessee's method for funding special education needs revision. (See the section "Funding and Funding Methods.")

Least Restrictive Environment / Inclusion

Key Points

- *Although the concepts of least restrictive environment and inclusion are not exactly the same, they are related.*
- *A national debate continues regarding whether schools should institute "full" inclusion—where all children are educated in regular classrooms—or whether schools should continue to provide separate alternatives for some special education students.*
- *Issues related to inclusion encompass funding methods, labeling of students, assistive technology, and whether special education students' scores are included in state standardized testing.*
- *Some systems in Tennessee have included special education students in regular classrooms to a greater extent than others.*

One of the IDEA's central concepts is that all children should be educated in the least restrictive environment. To the greatest extent possible, children with disabilities are to be educated in regular classrooms rather than segregated from their nondisabled peers. Although the concepts of least restrictive environment and inclusion are not exactly the same, they are related. Neither federal statute nor regulations contain the word "inclusion," but both contain the mandate to educate children in the "least restrictive environment," which can translate to "including" special education students in regular education classrooms and activities to the greatest extent possible.

Much of the debate that centers on inclusion concerns whether "full inclusion" should be implemented—with all children educated full-time in regular classrooms regardless of the severity of their disabilities—or whether, as is actually required by federal law, special-needs students are placed in regular classrooms as often as possible, but with a continuum of educational services available to them.[24]

The National Association of State Boards of Education endorses full inclusion, which they say would require a complete overhaul of the current education system. The concept of inclusion is different from the older concept of mainstreaming. NASBE's vision is that all disabled students should be "included" rather than "mainstreamed." The distinction is this:

> Mainstreamed students pass in and out of general education classrooms throughout the day. Because they are frequently assigned to the school that houses the district's program for that disability category, mainstreamed students often attend schools that are far away from their home school, isolated from where siblings and friends attend...Inclusion, on the other hand, means that students attend their home school with their age and grade peers. It requires that the proportion of students labeled for special services is relatively uniform for all of the schools within a particular school district, and that this ratio reflects the proportion of people with disabilities in society at large...To the maximum extent possible, included students receive their in-school

[24] Parrish, p. 3.

> educational services in the general education classroom with appropriate in-class support.[25]

Full inclusionists also support the elimination of all special education placement options, including resource rooms, self-contained classrooms, and special day schools.[26] NASBE criticizes the current special education system, citing statistics showing that of the students generally classified as mildly or moderately disabled who are usually mainstreamed into the general education classroom for part or all of the school day, only 57 percent graduate with either a diploma or certificate of graduation and only 49 percent of out-of-school youth with disabilities aged 15-20 are employed within one to two years after high school.[27]

But, according to Douglas and Lynn Fuchs, professors of special education and co-directors of the John F. Kennedy Center's Institute on Teaching and Learning, while they believe more disabled children would benefit from being included in regular classrooms, general education will never be able to serve all children's needs. They use as an example the needs of children with behavior disorders who require a more controlled environment than a regular classroom provides. In addition, the Learning Disabilities Association, the National Joint Committee on Learning Disabilities, the American Federation of Teachers, and the National Education Association all reject the idea of full inclusion.[28]

According to the Fuchs' research, many strategies used successfully by special education teachers in special education settings do not transfer easily to most mainstream class-rooms. Most special education practices require an intensity of focus on the individual student, something that is impractical in a general education classroom with 25 to 35 students. "Moreover, special education's most basic article of faith—that instruction must be individualized to be effective—is rarely contemplated, let alone observed, in most general education classrooms."[29]

Advocates of those with hearing and visual impairments likewise reject full inclusion and support special schools.[30] They suggest that the least restrictive environment for many deaf and blind students is in the company of other deaf and blind students, rather than in regular classrooms.[31] Tennessee law allows parents or guardians of children who are legally blind to decide whether their children should attend regular classes alongside

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[25] National Association of State Boards of Education Study Group on Special Education, p. 12.
[26] Brenda Ellis, "Inclusive schools and the reform of special education," *Vanderbilt Register*, Nov. 28-Dec. 4, 1994, p. 1.
[27] National Association of State Boards of Education Study Group on Special Education, p. 8. The statistics cited within the NASBE report were taken from the *Fourteenth Annual Report to Congress* and the *National Longitudinal Transition Study*.
[28] Ellis, p. 2.
[29] Douglas Fuchs and Lynn S. Fuchs, "What's 'Special' About Special Education?," *Phi Delta Kappan*, March 1995, pp. 528-9.
[30] Ellis, p. 2
[31] Interview with Carol Westlake, Coalition for Tennesseans with Disabilities, August 4, 1995.

children who are not visually impaired or special classes at the Tennessee School for the Blind.[32]

Parents and others with a primary interest in regular education are also concerned that full inclusion would detract from the attention received by non-special education students, particularly if teaching resources are not increased.

Inclusion in Tennessee

Over the past five years, schools in counties throughout Tennessee have been experimenting with inclusion. Currently, school systems with pilot programs in inclusion include Anderson County, Davidson County, Dyer County, Sumner County, and Cleveland City. According to Nan Crawford in the Division of Special Education, the pilot programs represent an effort to discover the best practices for implementing inclusion in Tennessee's schools. The division has contracted for programs in school systems of varying sizes and in different locations throughout Tennessee. The division's involvement begins with helping to fund the salary for an inclusion facilitator in each participating system. The school systems must agree to allow other school systems to observe their methods firsthand. In addition, the participating school systems must agree to provide in-service training on inclusion for other school systems.[33]

Sumner County's inclusion program has been the longest-running pilot for Tennessee. According to Louise Smith, Sumner County's Special Education Supervisor, about 22 of the system's 34 schools have inclusion programs. Students in inclusion classes include some who have been diagnosed with attention deficit hyperactivity disorder (ADHD) and severely emotionally disturbed students (SED). Smith said that there are no pull-out programs for these students—all education occurs in regular classrooms where special education teachers are placed along with regular education teachers. The school system typically limits the number of special education students to five or six per classroom. According to Smith, TCAP scores show that the special education students in these programs have made improvements up to three and four times the national gain. While most still do not achieve at average levels, they are improving. She said that during the same period, regular education students' progress has not declined, so it appears that inclusion has not hurt their ability to learn.[34]

In addition, the Tennessee Education Association prominently featured a Jackson-Madison County school inclusion program in its August 1995 issue of *Professional Quarterly*. Alexander Elementary, according to the article, implemented what has become "acknowledged as an exemplary inclusion program" two years ago. Earl Wiman, principal of the school, decided to institute the program because he wanted to ensure that the school could design its own program rather than being forced to comply with a set of procedures designed by someone else. He notes certain advantages to inclusion for his school: general education students have become more understanding of disabled students

[32] *T.C.A.* §49-10-103(d)(1)-(3).
[33] Telephone interview with Nan Crawford, Division of Special Education, January 25, 1996.
[34] Interview with Louise Smith, Special Education Supervisor, Sumner County Schools, August 8, 1995.

and special education teachers help general education teachers with all students, not just special education students.[35]

The department has also been conducting, as part of its training for teachers and administrators, a "collaborative classrooms" academy, which began during the 1995-96 school year. While not the actual focus of the academy, inclusion is a significant part because trainers emphasize regular and special education teachers working together. The academy, which is not required, is conducted at least twice annually, but can only serve about 100 teachers. According to department staff, the response from participating teachers has been very good, but it is not yet clear how the results will be applied in Tennessee schools.[36]

Inclusion and other issues

The inclusion debate cuts across other special education issues as well, including labeling students and funding special education services. Labels are assigned to students mostly to identify them for specific services. In many states, as in Tennessee, labels are also tied to funding and are designed so that more dollars are generated for children receiving more extensive services. According to NASBE, however, "...these funding practices have also contributed to the segregation of students into isolated programs and have served as an incentive for over-identification of students so that school districts could receive more support from the state and local governments."[37] (See also the section *Funding and Funding Methods.*)

In addition, the extent to which a state includes students with disabilities in data collection programs is, according to NASBE, one measure of its inclusion policy. In Tennessee, each special education student's multidisciplinary team determines whether or not that student should take the series of standardized tests known as the Tennessee Comprehensive Assessment Program (TCAP) tests. The decision is recorded in the student's individualized education plan (IEP). Tennessee includes the scores of those special education students who take the tests in the assessment of schools and systems, but excludes the records of any student who is eligible under federal law for special education services from use as part of the value-added assessment of teachers (TVAAS).[38] This type of exclusion may provide an incentive for teachers and administrators to encourage the placement of certain low-achieving children in special education categories in order to improve overall test scores.[39]

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[35] Tennessee Education Association, "One School's Interpretation of Inclusion," *Professional Quarterly*, Vol. 1, No. 1, August 1995, pp. 3-4.
[36] Telephone interview with Susan Hudson, Department of Education, July 26, 1996.
[37] National Association of State Boards of Education Study Group on Special Education, p. 31.
[38] *T.C.A.* §49-1-606(a).
[39] See also *The Measure of Education: A Review of the Tennessee Value-Added Assessment System*, Office of Education Accountability, April 1995.

Recommendation: The State Board of Education and the Department of Education may wish to consider working with special education constituency groups to provide a comprehensive special education inclusion policy addressing these and other issues. In addition, the Board and the Department may wish to showcase successful inclusion projects to encourage similar successes in other systems.

In addition, the board and the department should step up efforts to provide staff development regarding inclusion, particularly for regular education teachers. Currently, such training exists, but is not required and serves only a small number of teachers. However, training regular education and special education teachers to work together could result in allowing more disabled students to be educated in regular classrooms. At the very least, increasing efforts to allow more students to be served in regular classrooms moves closer to fulfilling the federal mandate to educate all children in the least restrictive environment.

Assistive Technology

Key Points

- *Assistive technology can help disabled students work more independently in a regular classroom setting, thus fulfilling the federal mandate to educate students in the least restrictive environment.*
- *In certain cases, assistive technology may assist in reducing students' needs for other school services.*

Another issue related to inclusion is the use of assistive technology by disabled students in the classroom. Congress's Office of Technology Assessment describes assistive technology for special education students as "revolutionizing," allowing them to work more independently in regular classrooms and giving teachers flexibility to better meet individual students' needs.[40] The use of assistive technology for some children with disabilities can make inclusion a smoother process for both students and teachers, giving students new opportunities to communicate with others and the means to learn more easily alongside their nondisabled peers.

In a nine-state survey conducted in 1992, the National Council on Disability found that technological aids helped 27 percent of disabled minors move into regular education classrooms from special education classes. Forty-five percent of students (or their parents) credited the devices with reducing other school services the students had been receiving.[41]

Tennessee Code Annotated §49-10-103(c)(2) requires that "[i]mpediments to learning and to the normal functioning of children with disabilities in the regular school environment shall be overcome by the provision of special aids and services rather than by separate schooling for the disabled." Some school systems in Tennessee have used assistive technology to move special education students into regular classrooms. Robertson County Schools has several students using a device called Easy Listener, basically an earphone that allows the teacher to speak directly to the student. This device is useful for students with hearing and listening problems, as well as for students with attention problems. In addition, the school system has a nonverbal student with multiple disabilities who is now able to spend most of the school day in the regular classroom because of a special communication device. Prior to having the device, the child had been considered largely incapable of learning.[42]

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[40] U.S. Congress, Office of Technology Assessment, *Teachers and Technology: Making the Connection,* OTA-EHR-616 (Washington, D.C.: U.S. Government Printing Office, April 1995) pp. 67-68.

[41] Audrey Choi, "Free to Learn: Computers designed for the disabled are reshaping the field of special education," *The Wall Street Journal,* November 13, 1995, R30.

[42] Telephone interview with Faye Taylor, Robertson County Schools, February 14, 1996.

Recommendation: The Department of Education and the State Board of Education should explore the use of increased assistive technology for disabled students in Tennessee schools. Successful uses of assistive technology by disabled students in Tennessee schools should be showcased to all systems, and should emphasize cases that have resulted in students' being able to learn in less restrictive environments.

Health Care Services in Schools

Key Points

While the delivery of health care services in schools is not strictly a special education issue, it does affect special education students and staff. It should be noted, however, that the controversy regarding health care services in schools pertains to both regular and special education students.

- *Some students have health care needs and require assistance, such as catheterization or the administration of medicines, in order to attend school. Students with such needs include both regular and special education students.*
- *Tennessee recently passed legislation for providing health care services in schools that is more restrictive than that in many other states and more restrictive than guidelines adopted by the National Council of State Boards of Nursing and the Tennessee Board of Nursing.*
- *According to a recent Attorney General's opinion, the new legislation supersedes a policy recently adopted by the Tennessee Board of Nursing that would have allowed nurses to train and delegate certain health care tasks to unlicensed personnel in schools.*
- *A survey conducted by OEA indicated that 131 nurses, both full- and part-time, were working in 117 of the 139 school systems in Tennessee during 1994-95.*

Background

During the past several years, as the provisions of the IDEA and Section 504 have been more fully implemented, more children with a variety of health care needs have been educated in regular schools throughout the nation, including those in Tennessee. Many of these children, though not all, are also special education students. The services that must be provided for students with health care needs, whether they receive special education services or not, include procedures such as clean intermittent and sterile catheterization, gastrostomy tube feeding, maintenance and cleaning of tracheostomies, blood glucose monitoring, and the administration of medicines. These procedures are considered to be "related services" under the IDEA, and must be provided in order to allow some children to attend school.[43]

A recent uncertainty has developed in Tennessee regarding who can legally deliver health care services in schools. The Tennessee Department of Education's policy, backed by a U.S. Supreme Court decision, once permitted teachers and teacher aides to provide these services to students—however, because of state statutes brought to light by a 1994 U.S. district court decision, the department advised school systems to allow only licensed medical personnel to provide health care services. To complicate matters further, a few

[43] 34 CFR 300.16(b)(4).

months after the departmental change in policy, a U.S. appeals court reversed the district court decision. The details of the case are discussed in this section.

In addition, actions have been taken in the last few months by both the Board of Nursing, the board that regulates the practice of nursing in Tennessee, and the General Assembly, regarding the appropriate personnel to provide health care procedures in school. The Board of Nursing adopted a temporary policy that would allow nurses to delegate certain procedures to appropriately trained unlicensed personnel in schools. However, Public Chapter 979 (1996) passed by the General Assembly appears to have superseded that policy, requiring that only appropriately licensed health care professionals can perform certain health care procedures in schools and at related school events.

In an effort to determine the scope of the problem, the Office of Education Accountability, in the fall of 1995, conducted a survey of Tennessee school superintendents. The officials were asked to identify for the 1994-95 school year:

- the types of health care services provided in Tennessee schools;
- who has been performing or delivering the services; and
- the number of school nurses working in Tennessee's school systems.

The results from that survey are displayed throughout this section. It should be noted that 117 of the 139 school systems responded. Several systems indicated that they have not routinely kept some of this information and, therefore, some of their answers are estimates rather than exact figures.

Why students with health care needs attend regular schools

Twenty years ago children with conditions that confined them to wheelchairs and children with many other disabling conditions often were not allowed to attend school. But with passage of both the IDEA and Section 504 of the Vocational Rehabilitation Act in the early seventies, and as social changes have gradually occurred creating more awareness of the disabled community, children with a variety of needs and health problems attend regular schools. Educating special needs children in regular schools allows disabled and non-disabled students opportunities to socialize with each other, and also helps disabled students learn how to function in a world that largely favors the non-disabled. The table below represents the number of regular and special education students who required the corresponding procedures in the 117 school systems responding to the survey.

How many students received the following health care procedures in Tennessee schools during the 1994-95 school year? (117 school systems of 139 reporting)

Procedures	Regular education students	Special education students
clean intermittent catheterization	38	114
sterile catheterization	8	24
maintenance of a tracheostomy	5	34

tube feeding	36	155
blood glucose monitoring	139	49
breathing machine	173	81
other	151	192
TOTALS	550	649

The totals, 550 for regular education students and 649 for special education students, represent about .089 percent and .43 percent, respectively, of those student populations.[44] Although the number of children with health care needs in schools is a relatively small proportion of all students with disabilities, there is some evidence to suggest that this population is increasing. Between the 1992-93 and 1993-94 school years, significant increases occurred nationally in students with traumatic brain injury and other health impairments.[45] Both of these categories include children with health problems.[46]

Several reasons have been suggested for this increase, including advances in medical technology. Some conditions that years ago might have been fatal may now be treated as chronic disabilities. The Center for Special Education Finance (CSEF) credits other factors as well: low birthweight babies, substance abuse among pregnant women, and substance abuse among youth, resulting in newborn perinatal infection by pregnant mothers.[47]

In addition, the number of children diagnosed with attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) appears to be increasing.[48] Often, these children are prescribed medication (commonly Ritalin, although other similar medicines are also used), and it becomes the responsibility of school personnel to administer doses to them during the school day. The Office of Education Accountability's survey indicated that administration of medicine is the procedure most often required by students in Tennessee's schools.

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[44] The regular and special education populations used as a base for figuring these percentages were determined by: summing the total ADMs reported by the 117 systems that responded to the survey and deducting from that total the number of children with disabilities for those systems from Table 11 of the Department of Education's Annual Statistical Report.

[45] U.S. Department of Education, *Seventeenth Annual Report to Congress on the Implementation of The Individuals with Disabilities Education Act,* 1995, pp. 10-11. The number of students in the traumatic brain injury category increased 33.7 percent (from 3,960 to 5,295); the number in the other health impaired category increased 26.1 percent (from 66,063 to 83,279).

[46] "Other health impairment" means, according to 34 CFR 300.7, having limited strength, vitality or altertness, due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes that adversely affects a child's performance. "Traumatic brain injury" means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychological impairment, or both, that adversely affects a child's educational performance.

[47] Thomas B. Parrish and Deborah A. Verstegan, *Fiscal Provisions of the Individuals with Disabilities Education Act: Policy Issues and Alternatives*, Center for Special Education Finance, June 1994, Palo Alto, CA, p. 11.

[48] Seventeenth Annual Report to Congress, pp. 11-12; Lynn Schnaiberg, "Experts, Educators Question A.D.D. Diagnoses," *Education Week*, Feb. 22, 1995, pp. 1 and 9; Monika Guttman, "The Ritalin Generation," *USA Weekend*, Oct. 27-29, 1995, pp. 4-6.

How many students during the 1994-95 school year were administered medicine one or more times per day for a period exceeding two weeks? (117 of 139 school systems reporting)

Regular education students	Special education students
14,944	8,592

How many students during the 1994-95 school year were administered the prescription drug Ritalin during the school day? (117 of 139 school systems reporting)

Regular education students	Special education students
7,229	4,913

Awareness of the number of students with health care needs in Tennessee's schools has also increased as a result of the U.S. Department of Justice's recent investigation and continued monitoring of Arlington Developmental Center near Memphis. Among other requirements, the Justice Department in 1994 ordered that all school-age children residing at Arlington—a center for people with profound or severe retardation, often with multiple disabilities—had to be moved to group homes throughout Shelby County. Once in group homes, the children, formerly educated by the Department of Mental Health and Mental Retardation in the confines of the developmental center, then become the educational responsibilities of local educational agencies. The other three developmental centers in Tennessee—Clover Bottom in Nashville, Greene Valley in Greeneville, and Nat T. Winston in Bolivar—have been ordered to institute the same changes.

Who should deliver health care services in Tennessee schools?

In April 1996, the General Assembly passed Public Chapter 979, which will allow only licensed health care professionals to perform certain health care procedures in schools.[49] According to a recent Attorney General's opinion, that action superseded a policy adopted only one month earlier by the Tennessee Board of Nursing, which would have allowed nurses in Tennessee's schools to supervise, train, and delegate procedures to unlicensed personnel.[50]

These actions followed a series of events that began in 1994 with a U.S. District Court decision in response to the case *Neely v. Rutherford County Schools.*[51] The *Neely* court ruling ordered Rutherford County Schools to provide a full-time licensed nurse or respiratory care specialist to assist a seven-year-old student with Congenital Central Hypoventilation Syndrome. The child had a breathing tube that required suctioning and if the tube became dislodged, resuscitation was necessary to keep her alive. The child's parents had sought full-time nursing services for her while she attended school, and the

[49] Public Chapter 979 was passed as House Bill 2712.
[50] Attorney General's Opinion No. 96-11, August 30, 1996.
[51] 851 F. Supp. 888 (M.D. Tenn., 1994) 21 IDELR 373.

school district hired a nursing assistant to provide the care. The parents, however, maintained that she required a nurse or respiratory care professional. An administrative law judge ruled that the district was not required to pay for this care. The parents then filed suit in district court, which held for the parents and directed the district to provide the care.

The district court judge found that state law required that an individual in this life-threatening condition receive services from "only a licensed practical or registered nurse, a respiratory care specialist, certain relatives, or the patient him or herself, if possible," referencing *Tennessee Code Annotated* §63-6-402 and §63-6-410. While these provisions do not contain specific language prohibiting unlicensed persons from performing health care procedures in schools, they do specify that only certified respiratory care therapists, registered nurses, and licensed practical nurses are authorized by state law to practice respiratory care.

Following this ruling, on June 28, 1995, Joseph Fisher, Executive Director of the Division of Special Education, issued a memorandum to school superintendents stating: "It is imperative that each local education agency employ or contract with persons licensed by the Health Related Board to perform medical procedures in order to enable students to attend school." The memo said that the department had been previously unaware of the provisions of Tennessee law that govern the practice of nursing and respiratory care practitioners, and specifically how the provisions affect the delivery of health care services in schools. These portions of state law, according to the memo, "indicate that local school personnel who are not licensed by the Health Related Board but who are performing these medical procedures would be included in the definition of practicing medicine without a license."

Prior to this directive, departmental policy permitted schools in Tennessee to use teachers, teacher aides, and other school personnel to perform health care procedures that allowed some students to attend school. The basis for this policy was the 1984 Supreme Court ruling in *Irving Independent School District v. Tatro*.[52] In *Tatro*, parents of an eight-year-old girl with spina bifida sued the school district because the child's Individualized Education Program made no provision for school personnel to provide the child with catheterization, a procedure necessary for her attendance in school. The Supreme Court ruled that the procedure was not a "medical service" under federal law, which schools are required to provide only for diagnostic and evaluative purposes. Catheterization, the Court said, was a "related service" under the Education for the Handicapped Act (now IDEA), a procedure that is necessary for some disabled children to benefit from special education. Under EHA, a state receiving federal funds must provide students with a "free, appropriate public education," which includes related services.

Furthermore, the Supreme Court found that clean intermittent catheterization "is a simple procedure that can be performed in a few minutes by a layperson with less than an hour's training." Also: "It bears mentioning that here not even the services of a nurse are

[52] 458 U.S. 883, 104 S. Ct. 3371 (1984), 1983-84 EHLR 555:511.

required; as is conceded, a layperson with minimal training is qualified to provide [clean intermittent catheterization]." That ruling formed the basis for the department's policy that properly trained teachers, teacher assistants, or other trained personnel could legally perform procedures deemed "related services" under the IDEA.

The Rutherford County school system filed an appeal in the United States Court of Appeals for the Sixth Circuit, and the appeals court reversed the district court's decision.[53] The appeals court decision, reached November 2, 1995, examined whether the care under consideration was a related service under the IDEA, which would obligate the school system to provide it at no cost to the parents. In reaching its conclusion, the court interpreted the *Tatro* decision "...to be that a school district is not required to provide every service which is 'medical in nature.'...We believe it is appropriate to take into account the risk involved and the liability factor of the school district inherent in providing a service of a medical nature such as is involved in this controversy." The appeals court ultimately found that the services required for the child in the case were "inherently burdensome" for the school district, in the sense that constant one-on-one care was required and no other child could benefit from the services of the attendant. The court determined that the care requested by the child's family fell within the "medical services" exclusion to the IDEA, and thus was not a related service.

The Office of Education Accountability's survey indicates that school systems previously often relied on teachers, teacher aides, and other individuals to provide health care services to students. The Tennessee Education Association, which represents teachers throughout the state, opposes using teachers and teacher aides to deliver health care services to students. Kathy Woodall, former president of TEA, stated the organization's position at a July 1995 meeting of the legislature's Select Oversight Committee on Education: "Teachers are hired to teach. Teacher assistants are hired to assist teachers in teaching....Teachers are afraid—and legitimately so—that they may harm a student in dispensing medications and performing medical procedures."

A case in Knox County illustrates the dissatisfaction that exists at least among some teaching staff regarding the issue. In 1993, the Knox County Board of Education fired five teacher aides for refusing to take training for catheterization. According to Barbara McGarity, Assistant Superintendent of Supplementary Student Services in Knox County Schools, the aides were fired for insubordination after refusing training, even though they were aware that following the training process they would not be required to perform the procedure. The school system received assurance from the state Department of Education that its actions had been proper and were supported at the time by the *Tatro* decision. In December 1993, the five aides brought suit against the school board, seeking reinstatement and $250,000 each in damages. The suit is pending.[54]

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[53] *Neely v. Rutherford County Schools*, No. 94-5755 (6th Cir. Nov. 2, 1995). Supreme Court denied certiorari.

[54] Telephone interview with Barbara McGarity, Assistant Superintendent of Supplementary Student Services, Knox County Schools, Feb. 20, 1996.

Chronology of events affecting the delivery of health care services in Tennessee schools

1984	• The Supreme Court rendered the *Tatro* decision, which shaped the Tennessee Department of Education's policy to allow unlicensed personnel to provide certain health care procedures in schools.
1993	• Five teacher aides in Knox County were fired for refusing to be trained to perform catheterization. They filed suit against the school system in December.
1994	• A U.S. District Court rendered the *Neely* decision requiring Rutherford County Schools to hire a full-time respiratory therapist to provide care to one student during the school day.
6/28/95	• The Department issued a memorandum advising school systems to hire only licensed health care professionals to provide health care services in schools.
9/95	• The Tennessee Board of Nursing adopted a policy allowing the self-administering of medicines by students judged capable of doing so.
11/2/95	• The United States Court of Appeals for the Sixth Circuit reversed the *Neely* decision.
3/96	• The Tennessee Board of Nursing adopted a policy allowing nurses to delegate certain procedures to unlicensed personnel in the school setting.
4/96	• The General Assembly passed Public Chapter 979, which requires school systems to hire only licensed health care professionals to perform health care procedures in schools.

Implications for Tennessee's School Systems

Although the *Neely* case was reversed in favor of the school system, problems related to health care delivery in Tennessee schools still exist. According to the results of OEA's survey, only about 62 of the 117 responding school systems employed school nurses during 1994-95. Of these, about 13 employed nurses only part-time. However, school systems are now required to use only "appropriately licensed health care professionals" to perform health care procedures for students under the provisions of Public Chapter 979 (1996), recently passed by the General Assembly. The law permits unlicensed personnel to assist in the "self-administration" of medications, in cases where students are judged to be competent to self-administer medication with assistance, but will not permit unlicensed personnel to perform other health care procedures.

Number of nurses working in Tennessee school systems during the 1994-95 school year. (117 of 139 systems responding)

	Full-time	Part-time
Registered Nurses	77	24
Licensed Practical Nurses	27	3

While the state funding mechanism for education, the Basic Education Program (BEP), currently generates funding for one nurse per 3,000 students (based on average daily membership), school systems are not required to spend the money to hire nurses. As with all other components of the BEP, school systems have had a great deal of discretion over how to spend their BEP funds. During the 1996 legislative session, the General Assembly also passed Public Chapter 894,[55] which will require that each school system use BEP funds to "directly employ or contract for a public school nurse" for every 3,000 students when the BEP reaches full funding (which is expected to be FY 1997-98). Any school system choosing not to do so must advise the Department of Education of the alternative arrangement it has chosen in order to meet students' health needs. (The provisions of P.C. 979, however, may render P.C. 894 unnecessary, since schools will have to provide health care services immediately using licensed personnel only and cannot wait for full funding to provide these services.)

If the provisions of P.C. 894 had been effective in 1994-95, schools in Tennessee would have had to hire 315 school nurses based on the BEP requirement that each system have a minimum of one nurse for every 3,000 students with a minimum of one per system. OEA's survey results indicated that the 117 systems responding, during the 1994-95 school year, employed a total of 131 nurses statewide, including both full- and part-time nurses.

In some communities, obtaining a sufficient number of nurses in schools may be complicated by the lack of available health care services. A small school system in Tennessee, for example, may have only one or two children during the school year who require health care services. But if the county where the school system is located has no hospital and its local board of health is open and staffed by a nurse only part-time, finding

[55] Public Chapter 894 was passed as House Bill 177.

"persons licensed by the Health Related Board" to work in the school system may be difficult, if not impossible.

In addition to the staffing problems that this may create in some schools, the law may cause concerns related to the providing of Occupational Therapy and Physical Therapy (OT and PT) services. Some of these services previously have been delegated to unlicensed professionals in schools, but the new law may be interpreted to prohibit such delegation.

Attempts at Resolution

The General Assembly began studying the issue of health care delivery in schools in the spring of 1995 when it passed House Joint Resolution 80. The measure charged the Select Oversight Committee on Education to review "the specialized health care needs of medically fragile or technologically dependent children in the state's public schools and the examination [or] evaluation of alternative ways to provide personnel or services that will reduce or eliminate the involvement of teachers."

The department's subsequent memo in June 1995 exempted teachers, as well as any unlicensed personnel, from providing health care services to students. Essentially, the General Assembly's later actions followed suit. (See the previous section.) Prior to the legislative action, the Departments of Health and Education had been working in conjunction with the state Board of Nursing to find long-term solutions for school systems. An independent regulatory body, the Board of Nursing is responsible for licensing those who practice nursing in the state, as provided in *Tennessee Code Annotated* Title 63, Chapter 7. In essence, the Board of Nursing defines and governs the practice of nursing in Tennessee, and determines the procedures that must be performed or supervised by nurses. Board actions, rulings, and orders have the same weight of law as do those of other quasi-judicial bodies, but are superseded by legislation passed by the General Assembly.

In response to the problem, the Board adopted policies and guidelines that apply specifically to the school setting, and address the administration of medicines and the delegation of certain procedures to unlicensed personnel. The policies and guidelines were developed and proposed by the Department of Health, with input from the Department of Education. (See Appendix G for a copy of these policies.)

In September 1995, the Board of Nursing adopted a policy on the self-administering of medicines by students who are judged capable of doing so. The board agreed that unlicensed personnel could provide assistance in the self-administration of medicines in the school setting under certain conditions:

- the student must be competent to self-administer the authorized and/or prescribed medication with assistance.
- the student's condition for which the medication is authorized and/or prescribed must be stable.
- the administration of the medicine must be properly documented.

- guidelines consistent with the National Council of State Boards of Nursing and the National Association of School Nurses must be developed and followed.

In March 1996, the Tennessee Board of Nursing adopted a policy allowing the delegation of certain procedures to unlicensed assistive personnel. However, this policy was to be effective for only one year. The board authorized registered nurses in school settings to delegate to unlicensed personnel "those nursing tasks supported by national standards as safe and appropriate to delegate, according to the premises and delegation decision process outlined in the NCSBN [National Council of State Boards of Nursing] paper [1995 Delegation Decision-Making Process]." The board agreed that such delegation in the school setting would not constitute the unlawful practice of nursing as long as guidelines for the delegation of procedures developed by the Department of Health were followed.

The newly passed state law, however, requires that only "appropriately licensed health care professionals" must perform health care procedures in schools and at related school events "in accordance with applicable guidelines of their respective regulatory boards." It appears that the intent of the legislature is to require school systems to employ or contract with licensed health care professionals. Since only licensed health care professionals will be allowed to perform all health care services in schools with the exception of the self-administration of medicines, those school systems that currently neither employ nor contract with registered nurses will have to do so in order to serve students with health care needs. The Board of Nursing policy, had it been implemented, would have represented a more easily achievable "step up" for Tennessee's schools because schools would have had to contract with or hire nurses in order to allow delegation, but could have filled many of the needed positions with unlicensed personnel.

Other provisions of Public Chapter 979 require that the Department of Education and the Department of Health jointly compile an annual report of the medications and health care procedures administered to students in all public and private accredited schools in the state. The report is to be provided to the Governor and the General Assembly by August 31 of each year, and is to include recommendations for meeting comprehensive school health needs.

Health Care in Schools in Other States

According to a survey conducted by the University of Colorado Health Sciences Center, in 1993-94 approximately 34 of the 50 states allowed delegation of health care services to unlicensed personnel in schools.[56] See Appendix H for a summary of each state's provisions.

[56] *State Nurse Practice Acts and Unlicensed Assistive Personnel*, Revised June 1995, Survey conducted and analyzed by Marjorie J. Long, JD, as part of the project "Developing Policy and Practice to Implement I.D.E.A. Related to Invasive Procedures for Children with Special Health Care Needs," funded by U.S. Department of Education and carried out at the University of Colorado Health Sciences Center, School of Nursing, Marilyn J. Krajicek, Ed.D., R.N., F.A.A.N., Project Director/Associate Professor.

The national survey also indicated that schools across the country often use unlicensed assistive personnel to provide some health services, including catheterization, routine suctioning, and tube feeding. Apparently, smaller districts use health assistants less frequently than districts with 2,500 students or more. School nurses supervise the assistants in 82 percent of the districts in which they are employed. Nurses, according to the survey, were employed by more than half the school districts. The mean number of full-time nurses was 2.33 per district. Twenty percent of all districts use health paraprofessionals and nine percent use licensed practical nurses. The most common ratio of nurses to students is one nurse to 750 or fewer students, reported by 37 percent of the districts responding. In another one-third of the districts, the ratio is one nurse to 751-1,000 students. Fourteen percent of the nurses are responsible for attending to students in six or more buildings.[57]

Selected States

Adequate health care for students in public schools must be provided in all states. Not surprisingly, the problem of determining the proper personnel to provide health care services to students is not exclusive to Tennessee. Actions that have been taken in other states, such as California, Iowa, and Washington, may provide alternatives for Tennessee officials to consider.

California—In 1990, the California Department of Education revised *Guidelines and Procedures for Meeting the Specialized Physical Health Care Needs of Students*, originally published in 1980. The comprehensive publication represents input from physicians and surgeons, nurses, school administrators and teachers, parents, and advocates. It defines terms and addresses the issues relating to providing health care services in the school setting; outlines and provides illustrations of the accepted procedures to use when health care services are provided that have been approved by the child's primary care provider; provides information concerning the prevention of contagious diseases; and provides guidance and information for school nurses delivering health services to children with orthopedic conditions.

The guidelines in the manual specify that all providers of specialized health care services in schools must be supervised by a school nurse, a public health nurse, or a physician or surgeon who meet the requirements of California law. "Specialized physical health care services" are defined in the manual as having the following characteristics:

1. They are necessary during the school day to enable the child to attend school.
2. They can be learned by the average person without requiring prior medical training.
3. They do not require extensive amounts of time for their administration.

[57] *School Health Professional*, "School Nursing is Alive and Well, Says Comprehensive Survey of School Health Programs," June 7, 1995, pp. 4-5. Note: The article states that the survey did not receive a high response rate: 482 school districts of the 1,677 who were sent a copy of the survey completed and returned it. However, it also states that those who did respond were representative of school districts across the country, based on geographic distribution and district size.

4. They do not require a physician to administer them.[58]

A bill under current consideration in California's state legislature would require the governing board of each school district to notify students' parents or guardians at the beginning of each academic year of: the ratio of full-time school nurses to pupils, the degree to which the ratio exceeds 1,500 pupils per nurse on a district-wide basis, and the average number of hours per week that a school nurse is at a school site; whether the supervisor of school nurses is a nurse or an administrative person without a nursing background; and whether the nurses employed by the school district meet the qualifications of a school nurse, as specified in state statute.

Iowa—In 1988, the board of nursing in Iowa challenged the legality of delegating nursing duties to teachers and issued a recommendation that each school district employ a registered nurse to provide school health services. According to school officials, one-third of Iowa's 436 districts did not employ registered nurses. Early that year, an amendment requiring schools to hire registered nurses was deleted from an education bill because it was not financially feasible. The board of nursing countered by issuing a position paper, which contained a list of the personnel necessary to perform certain procedures. The board agreed to drop the list if the Department of Education would agree to write rules for serving students with special health needs. The department agreed, and now operates under written rules, using a combination of nurses and unlicensed personnel.[59]

The Iowa Department of Education has appealed a case that has similarities to Tennessee's *Neely* case. An Iowa school district was required to provide health services and reimbursement for past expense to a 12-year-old medically fragile student, paralyzed from the neck down, dependent on the use of a ventilator for life support, and with other medical needs. The court ruled that the student's health care needs did not fall under the medical services exclusion of the IDEA, but were school health services that the district was required to provide as a related service. The court also ruled that the increased expense to the district of hiring a full-time registered nurse for the child's care—which ranged between $20,000 and $30,000—was not considered burdensome to the district.[60]

Washington—The Washington State Board of Nursing has issued guidelines for procedures that can be delegated to unlicensed personnel, including administration of medications, tube feeding, insulin administration, ventilator dependent patients, and drawing syringes. The board also defines the level of supervision of unlicensed personnel that is required. Under both the Washington nurse practice act and the board of nursing guidelines, not all responsibilities can be delegated; the nurse must supervise and evaluate the performance of the unlicensed person after training. One source notes that because the

[58] California State Department of Education, *Guidelines and Procedures for Meeting the Specialized Physical Health Care Needs of Pupils*, 1990, pp. I-4 - I-5.
[59] Lisa Jennings, "California Teachers Request End to Medical Duties," *Education Week*, Vol. 7, Issue 30, April 20, 1988, p. 10; and telephone interview with Charlotte Burt, Iowa Department of Education, March 6, 1996.
[60] Cedar Rapids Community School District, 22 IDELR 278.

statute does not provide a specific list of procedures that can be delegated, significant discretion still remains with the nurse, the results of which can be inconsistency in delegating, training, and supervision among districts.[61]

Summary

Even though both the General Assembly and the Board of Nursing have taken steps to address delivery of health care in schools, the issue still has not been resolved. Recent legislation requires school systems that do not currently employ or contract with licensed health care professionals to do so in order to serve students with health care needs, and requires "appropriately licensed health care professionals" to perform health care procedures. The new law apparently supersedes the policy recently adopted by the Board of Nursing that would allow delegation to unlicensed personnel. Few school systems employed an adequate number of health care professionals during the 1994-95 school year, but will have to do so in order to comply with the new law.

Recommendations: The General Assembly may wish to reconsider authorizing local education agencies to permit unlicensed persons to assist in providing some health care services to students in Tennessee schools. The Board of Nursing adopted a temporary policy to allow delegation to unlicensed personnel in the school setting, which should be followed for a period of time to determine its effectiveness. Using unlicensed personnel is prevalent in many states and was policy in Tennessee until recently. Some school systems may be hindered from hiring or contracting with a sufficient number of nurses for reasons beyond their control.

The General Assembly may want to amend the law to allow occupational and physical therapy services to be delegated as they have been previously.

The Department of Education, the State Board of Education, and the Department of Health should work together to develop comprehensive guidelines for delivery of health care services in Tennessee's schools. This process should include input from the appropriate health related boards and school nurse organizations and associations, as well as teachers, school administrators, other school personnel, and parents and students.

School systems should consider entering into inter-district contracts for health care services, if such agreements would be both feasible and economically beneficial. *Tennessee Code Annotated* §49-10-107

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[61] Sharan E. Brown, J.D., Ed.D., and Kim Cannon, J.D., "Students Who Require Special Health Care Services in the School Setting: Is Science Ahead of the Law?", *Law and Education Desk Notes*, Vol. 4, No. 5, Feb. 1994, pp. 19-20.

provides that school systems may contract with other systems for "educational, corrective or supporting services for children with disabilities."

If legislation were amended to allow schools to use unlicensed personnel with proper training and supervision, there are many possible alternatives that could reduce costs for school systems. Depending on their resources, school systems could provide training for volunteers, allow senior year nursing students to train in schools, and even pay for licensed practical nursing training for new hires with a minimum length of employment stipulated.

Discipline[62]

Key Points

- *Disciplinary procedures for regular education and special education students sometimes differ.*
- *Most of the required procedures for disciplining special education students are federally mandated.*

Discipline appears to be the most controversial issue surrounding the reauthorization of the IDEA. While regular education students have certain due process rights with regard to suspension and expulsion, the rights for special education students are more extensive. Some see the current approach to discipline for special education students as preferential treatment because it sometimes appears that disabled students receive lesser punishments than nondisabled students for the same violation. On the other hand, the procedural safeguards were incorporated into the law to prevent discriminatory practices against the disabled. [63]

Tennessee's approach to discipline for special education students, which closely follows federal policy, is contained in State Board of Education Rule 0520-1-3-.09, Section (9). The policy is based on significant court decisions and assorted Office of Civil Rights rulings. In addition, the State Board of Education has been working to develop a range of options for placing disruptive youth and has also specifically tried to address discipline of special education students.

The Office of Education Accountability surveyed school superintendents concerning discipline in Tennessee's schools during the fall of 1995; 117 of the 139 school systems responded. In the responding systems, the number of disciplinary actions taken against students for serious offenses (defined as "possession of weapons, property damage, drug-related actions, etc.") totaled 10,323 for regular education students and 3,275 for special education students during the 1994-95 school year. For the same time period the ADM for these 117 school systems totaled 762,814 and Table 11 in the Department of Education's Annual Statistical Report indicates that those systems reported 150,623 of the students were served by special education. Using these totals as a base, serious offenses were

[62] Most of the information in this section was taken from two sources: a memorandum to Chief State School Officers from United States Department of Education, Judith E. Heumann, Assistant Secretary, Office of Special Education and Rehabilitative Services, and Thomas Hehir, Director, Office of Special Education Services, dated April 26, 1995; and *Student Discipline*, a manual published by the Division of Special Education, Tennessee Department of Education, revised December 1993.

[63] "The extension of more elaborate safeguards for special education students...is largely a response to the historical tendency of schools to exclude troubled and troublesome students whenever they cost schools something in terms of order and efficiency." *The Ethics of Special Education*, Kenneth R. Howe and Ofelia B. Miramontes, Teachers College Press, Columbia University, New York, 1992, p. 34.

committed by about 1.69 percent of the regular education students and about 2.17 percent of the special education students in these systems.[64]

The table below contains the number of special education students receiving disciplinary actions of any kind during the 1994-95 school year, including in-school or out-of-school suspension, expulsion, alternative school, and any other (117 of 139 systems responding). The total, 15,491, represents approximately 10 percent of the special education students and 2 percent of the total ADM of the 117 systems responding.

Number of special education students receiving disciplinary actions (1994-95 school year) (117 of 139 systems responding)	Type of disciplinary action taken
5,809	In-school suspension
7,840	Out-of-school suspension
96	Expulsion
1,536	Sent to alternative school
210	Other
15,491	TOTAL

Source: Office of Education Accountability survey of school superintendents, Fall 1995

Suspension/expulsion for up to 10 days for special education students

According to federal and state requirements, if a special education student commits a violation at school, he or she may be suspended or expelled for up to 10 days. No prior determination of whether the misconduct was a manifestation of the student's disability is required before such action is taken. There are no specific actions that school districts are required to take during this time period, other than those required for nondisabled students.

However, the Office of Civil Rights has determined that a series of suspensions that are each 10 days or fewer in duration could create a pattern of exclusion that would constitute a "significant change in placement." A change in placement for a student receiving special education services is important, because it sets off a chain of procedural requirements mandated by federal law. OCR recognizes that some could use this method—suspending "problem" students for several periods each less than 10 days—to avoid the more complicated procedures that must be followed to effect a long-term suspension or expulsion. The factors that are considered when determining whether a student has been excluded from school to the extent that a change in placement has occurred include: the length of each suspension, the total amount of time the student is excluded from school,

[64] It should be noted that the survey question asked for the "number of disciplinary actions taken against students for serious offenses." The responses given, therefore, were not the number of students committing offenses, but the number of actions taken against students. Therefore, the figures given are cited as estimates rather than precise figures.

and the proximity of the suspensions to each other. Such determinations, according to OCR, must be made on a case-by-case basis.

Suspension/expulsion for more than 10 days for special education students

When a special education student commits an offense at school that could result in suspension or expulsion for more than 10 days, the student's M-team must first decide (1) whether the offense committed was a manifestation of the student's disability and (2) the appropriateness of the student's current placement.

- If the M-team determines that the offense *is* a manifestation of the student's disability, the student may *not* be suspended or expelled for more than 10 days, but instead must be placed in an alternative setting and must still receive educational services. The Office of Civil Rights recommends that school officials review the student's current educational placement to determine whether the services being provided are meeting the student's needs. If changes are needed, they should be implemented using the proper procedures.
- If the M-team determines that the offense *is not* a manifestation of the student's disability, the student may be suspended or expelled by the local board of education for a period greater than 10 days. When a student is suspended or expelled for more than 10 days, it is considered a change in placement. Before a change in placement can be implemented, the school district must give the parents written notice within a reasonable time before the proposed change is to take place. The notice must include the determination that the student's misconduct was not a manifestation of his or her disability, the basis for that determination, and an explanation of applicable procedural safeguards, including the parents' right to initiate an impartial due process hearing to challenge the determination and to seek administrative or judicial review of an adverse decision.

  If such a student is expelled, the provisions of the IDEA require that he or she must continue to receive educational services during the suspension or expulsion period. Although the federal law does not specify the particular setting for continued educational services, some possibilities include home tutoring, alternative school, another school, and in-school suspension. Services delivered must be based on the goals and objectives in each child's IEP and must be provided by a teacher who is endorsed in special education.

Disciplinary procedures for Section 504 students

Although the state's Division of Special Education is not responsible for Section 504 students, it is useful for the purposes of this discussion to understand the federal laws that govern the disciplining of such students. Section 504 of the Vocational Rehabilitation Act of 1973 contains many of the same provisions as P.L. 94-142—disabled students have the right to a free appropriate public education in the least restrictive environment and have due process rights to protect them from discrimination. Section 504 prohibits the discrimination against any "...otherwise qualified individual with handicaps in the United States...solely by reason of his/her handicap...under any program or activity receiving

federal financial assistance or activity conducted by any Executive agency..."[65] In the educational setting, it protects all students with disabilities whether or not they are categorized as special education students. Section 504 is much broader than IDEA and contains no categorical listing of disabling conditions. The Office of Civil Rights is charged with enforcing the requirements under Section 504. Section 504 contains no funding provisions.

As under the IDEA provisions, a Section 504 student may be suspended or expelled for more than 10 days only for a violation that was determined not to be a manifestation of the student's disability. However, unlike students protected under IDEA, Section 504 students do not have to receive educational services during such periods of suspension or expulsion if nondisabled students in similar circumstances do not continue to receive educational services.

IDEA and students with disabilities who bring firearms to school

According to OCR, the Gun-Free Schools Act applies to students with disabilities and must be implemented consistent with the IDEA and Section 504. The Act requires each state receiving federal funds under the Elementary and Secondary School Act to have in effect a state law requiring local educational agencies to expel for not less than one year any student who brings a firearm to school. The state law must allow the local educational agency's chief administering officer to modify the expulsion on a case-by-case basis. In addition, the Gun-Free Schools Act states that it must be construed in a manner consistent with the IDEA.

OCR interprets that the requirements of the IDEA and Section 504 can be met under the provision that permits modification of expulsions on a case-by-case basis. The same disciplinary procedures should be followed that are used for any other violation by a disabled student: the M-team must be convened to determine whether the offense was a manifestation of the student's disability. If it is determined to be a manifestation, the same procedures must be followed as for other violations: the student cannot be suspended or expelled for more than 10 days, but may be placed in an alternative setting with continuing educational services. If the violation is determined not to be a manifestation of the student's disability, the student may be expelled after the applicable procedural safeguards have been followed. Educational services must continue to be provided during long-term suspensions or expulsions (unless, as is the case for other violations, the student is classified under Section 504).

The IDEA was amended effective October 20, 1994, by the Improving America's Schools Act. The intent of the amendments, which have become known as the Jeffords Amendments after their sponsor Sen. James M. Jeffords (R-Vt.), was to provide additional flexibility to school authorities in protecting other students' safety when a disabled student brings a firearm to school. In this situation, the school district may place such a student in an interim alternative educational setting for up to 45 calendar days. The setting must be

[65] 29 *U.S.Code* §794.

determined by the student's M-team and cannot be imposed until the M-team has met and made the determination. If the parents disagree with the placement and choose to initiate a due process hearing, the student must remain in the alternative educational setting during the review proceedings, unless the parents and school district agree on another placement.

Under the IDEA, a student with a disability who has brought a firearm to school may be immediately suspended or subjected to in-school discipline that removes the student from the current placement for up to 10 school days. This provides more flexibility for the school district which has the option, before the student is placed in the interim alternative educational setting, of removing the student from school, using other in-school discipline, or placing the student in an alternative setting for 10 school days or less.

Significant court decisions / pending cases

The 1988 U.S. Supreme Court case *Honig v. Doe* resulted in the "stay-put" provision of P.L. 94-142, which prohibits local school systems from suspending or expelling children with disabilities for dangerous or disruptive conduct resulting from their disabilities during the pendency of review proceedings.[66] The Court ruled that any suspension in excess of 10 days constitutes a change in placement, and that if a system determines a child should be removed for more than 10 days, it must: (1) obtain parental consent to the exclusion; or (2) if parents do not consent, secure an injunction from the appropriate federal court to permit the system to extend the suspension/expulsion period.

A case originating in Tennessee has the attention of special educators across the country: *Chris L. v. Morgan.*[67] Some assert that this case, depending on its outcome, could have serious implications for schools regarding crimes committed by students on school grounds. Others say that the case is a simple matter of a school district not following the proper procedures.[68] The facts leading up to the case are these:

- Chris L. attended junior high school in Knox County, had shown some behavioral problems in elementary school, but had been determined by a multi-disciplinary team to be ineligible for special education.
- In May 1992, a pediatrician, to whom Chris L. was referred by a school psychologist, diagnosed the child with attention deficit hyperactivity disorder (ADHD) and prescribed Ritalin. Chris L.'s father brought the medicine to the school nurse.
- School officials did not initiate an evaluation of Chris to determine his eligibility for special education until February 1993, although they were aware of his diagnosis and throughout the 1992-93 school year his academic performance and behavioral problems worsened. Beginning in March 1993, Chris received counseling from a private psychologist.
- On May 11, 1993, Chris allegedly committed an act of vandalism by kicking a water pipe in the school lavatory until it burst.

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[66] 20 *U. S. Code* §1415(e)(3).
[67] 21 IDELR 783.
[68] Perry A. Zirkel, "Disabling Discipline?," *Phi Delta Kappan*, March 1995, pp. 568-9.

- On May 17, 1993, Chris and his father came to school, after his father was notified orally of a disciplinary hearing. This turned out to be what the administrative law judge referred to as a "makeshift" M-team meeting, where Chris was certified as disabled for the purposes of IDEA. Those present then discussed the act of vandalism, and the school principal stated that while the child's destructive behavior was related to his ADHD, the fact that he had been in a lavatory which he was explicitly not authorized to visit was not. The principal said that Chris's unauthorized presence in the lavatory would result in discipline. During this meeting, Chris's father was not advised of his rights under IDEA and was informed that he would hear from the juvenile officer if they decided to file charges.
- Later that day Chris L.'s father called the juvenile officer and was informed that a petition had been filed. He later received by mail a copy of the juvenile petition which had been sworn to May 12, 1993.

Chris L.'s father filed for a due process hearing under the IDEA. The superintendent did not call any witnesses, relying solely on documentary evidence. Chris's witnesses were his father and his psychologist who testified that "the student's recorded behavior was consistent with behavior of a child with ADHD" and that the act of vandalism was a manifestation of the child's disability. The hearing officer concluded that the school district had committed various procedural violations, including inadequate notice to Chris's father of the IEP team meeting. The hearing officer ordered the school district to seek dismissal of the juvenile court petition against Chris L.

The Knox County school system appealed to the federal district court in eastern Tennessee. The federal court ruled against the school system, stating that the filing by a school district of a juvenile court petition constitutes a change in educational placement for a child covered by the IDEA, and triggers the special due process protections provided for in *Honig v. Doe*. The school district argued that thus far the child had not been excluded from school for more than 10 days, and that the actions taken therefore did not constitute a change of placement. The court, however, focused on "the potential which juvenile court proceedings have for changing a child's educational placement in a significant manner." The court also rejected the school district's argument that Chris had been misdiagnosed as ADHD and suffered instead from "oppositional defiant disorder," noting that the district's expert had deferred to the psychologist's diagnosis of ADHD and had said that the two diagnoses are not necessarily conflicting.

The court upheld the hearing officer's order for the school superintendent to seek termination of the juvenile court proceeding and awarded attorneys' fees to Chris L.'s father. The case is currently on appeal in the Sixth Circuit.

NASBE

A newsletter published by the National Association of State Boards of Education in April 1995 listed the issues NASBE considers to be important regarding the disciplining of special education students:

- Data needs to be collected to document the extent of violence in schools and who is responsible for acts of violence. According to the newsletter, most national estimates of the incidence of violence in schools are based on surveys of teachers and students rather than on any actual data. "Hence, no one really knows how often students identified as disabled (who only comprise about 12% of the student population overall) are actually the perpetrators of school violence."[69]
- Policies addressing student evaluations for special education services should emphasize what could be done to prevent violent behavior. According to NASBE, many educators and administrators are unable to determine whether a behavior is related to a disability because of inadequate student evaluations.
- NASBE questions the effectiveness of the "zero-tolerance" policies—which require the expulsion of students caught with guns or other weapons at school—pointing out that schools that "expel students without educational alternatives merely turn students out into the streets, unsupervised, to wreak more havoc on the community at large." They suggest that school discipline policies for all students should include a range of sanctions, including detention, study carrels, verbal reprimands, in-school suspensions, school services programs, community service programs, and counseling programs.

Recommendation: Although most of the procedures regarding the disciplining of special education students are federally mandated, and do not allow the state much discretion, the State Board of Education should continue to work with educators to develop a range of options for placing disruptive youth and to address discipline of special education students. Further, the State Department of Education should implement these new policies by creating and distributing appropriate procedures, and by training school officials regarding the procedures.

[69] *Policy Update*, a newsletter published by the National Association of State Boards of Education, produced by the Center for Policy Research on the Impact of General and Special Education Reform, "Special Education Discipline," April 1995, p. 2.

Appendix A
People Interviewed

Ralph Bohannon
Assistant Superintendent
Greeneville City School System

Dr. Jennifer Butterworth
Least Restrictive Environment for LIFE Project
Knoxville, TN

Janice Cobb
(former) LEA Applications / TA Consultant
Division of Special Education
Tennessee Department of Education

Nan Crawford
Director, Program Services
Division of Special Education
Tennessee Department of Education

Jim DeMoss
(former) Executive Assistant
State Board of Education

Joe Fisher
Executive Director
Division of Special Education
Tennessee Department of Education

Judy Hasten
Monitoring Coordinator Consultant
Division of Special Education
Tennessee Department of Education

Steve Long
Supervisor of Special Education
Greeneville City School System

Dr. Wendy Long
Department of Health

Gloria Matta
Director, Management Services
Division of Special Education
Tennessee Department of Education

Barbara McGarity
Assistant Superintendent of Supplementary
Student Services
Knox County Schools

Steve Raney, Esq.
Director, Compliance
Division of Special Education
Tennessee Department of Education

Harry Repsher
LEA Applications / TA Consultant
Division of Special Education
Tennessee Department of Education

Margaret Robertson
Administrative Law Judge
State Board of Education

Louise Smith
Special Education Supervisor
Sumner County Schools

Chris Steppe
Audit Director
Tennessee Department of Education

Teresa Sullivan
Special Education Supervisor
Van Buren County

Faye Taylor
Robertston County Schools

Bob Tipps
Director, State Special Schools
Division of Special Education
Tennessee Department of Education

Carol Westlake
Coalition for Tennesseeans with Disabilities

Sarah Willis
Director, Early Childhood Services
Division of Special Education
Tennessee Department of Education

Richard Yoakley
Pupil Personnel Services
Knox County Schools

Appendix B: Significant Federal and State Legislation, Regulations, and Court Decisions

Federal Legislation and Regulations

In 1975, Congress passed **Public Law 94-142**, the Education for the Handicapped Act, firmly establishing the federal government's role in mandating education for children with disabilities. P.L. 94-142 was reauthorized in 1990 and was retitled the Individuals with Disabilities Education Act (IDEA). During 1995 it was again in the process of reauthorization in Congress, and, as of the printing of this report, had not been finalized. The law is based on the following basic premises:

- All children must receive a free and appropriate education without cost to their parents and regardless of the severity or type of disability.
- Procedural safeguards, including due process rights, must be ensured for all children with disabilities and their parents.
- Education in the least restrictive environment must be provided. To the maximum extent possible, students with disabilities must be educated with children who are not disabled.
- Individualized educational programming in the form of an individualized education plan (IEP) must be developed for each student receiving services under PL 94-142. These written plans must be developed by a multi-disciplinary team (M-team) composed of at least the child's teacher, parent(s) or guardian(s), a representative of the local school district, and the student, when appropriate.

P.L. 94-142 defines the term "children with disabilities" to be children with mental retardation, hearing impairments including deafness, speech or language impairments, visual impairments including blindness, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities.[1]

The regulations supporting the IDEA are contained in **34 Code of Federal Regulations, Part 300**. Among other things, the regulations more thoroughly define the concepts contained in the IDEA (e.g., free appropriate public education, least restrictive environment, individualized education programs, due process, disabling conditions, and others), describe the states' and local educational agencies' responsibilities, and describe the method of allocating federal funds under the IDEA.

Section 504 of the Vocational Rehabilitation Act of 1973 contains many of the same provisions as P.L. 94-142—disabled students have the right to a free appropriate public education in the least restrictive environment and have due process rights to protect them from discrimination. Section 504 prohibits the discrimination against any "...otherwise qualified individual with handicaps in the United States...solely by reason of his/her handicap...under any program or activity receiving federal financial assistance or activity conducted by any Executive agency..."[2] In the educational setting, it protects all students

[1] 20 *U.S.Code* §1401.
[2] 29 *U.S.Code* §794.

with disabilities whether or not they are categorized as special education students. Section 504 is much broader than IDEA and contains no categorical listing of disabling conditions. The Office of Civil Rights is charged with enforcing the requirements under Section 504. Section 504 contains no funding provisions.

The Program for Infants and Toddlers was created as Part H of the IDEA by **Public Law 99-457**, the Education of the Handicapped Amendments of 1986. Part H requires the states to address the needs of infants and toddlers (birth through age 2) with disabilities and their families through a statewide comprehensive, interagency, coordinated program of early intervention services. Part H was reauthorized in 1991 and new regulations were published in 1993. The intent of the law is to reduce the economic and social costs to society by minimizing the need for special education and other services after disabled children reach school age. According to *The 16th Annual Report to Congress on the Implementation of the Individuals with Disabilities Act*, states overall are still struggling with Part H issues, including: "the volume of policy decisions, the challenging fiscal situation confronted by the states, and a lack of lead agency direct authority or power....The familiar themes of fragmentation, duplication, and overlap continue to impede the development of cohesive, coordinated systems."

The **Americans with Disabilities Act of 1990** (ADA), Title II, extends Section 504's prohibition of discrimination on the basis of disability to all activities of state and local governments, whether or not they receive federal funds. This includes all public school districts.

Pertinent State Legislation

Prior to the passage of P.L. 94-142 in 1975, several states, including Tennessee, passed laws providing education services for disabled students. The Tennessee General Assembly in 1972 passed **Tennessee's Mandatory Education Law for Handicapped Children and Youth**, *T.C.A.* §§49-2912 to 2959 (Chapter 839 of the Public Acts of 1972):

> It is the policy of this state to provide, and to require school districts to provide, as an integral part of free public education, special education services sufficient to meet the needs and maximize the capabilities of handicapped children.

The state law governing special education in Tennessee is now codified as ***T.C.A.* Title 49, Chapter 10**. Much of what is contained in Tennessee's law mirrors the major provisions of IDEA. In addition, the law authorizes the State Board of Education to adopt rules and regulations, and modify them as needed, to implement the law. Some of the concepts are defined more extensively in the *Administrative Policies and Procedures Manual* published by the Division of Special Education, which contains both State Board of Education rules and the department's implementation policies and procedures.

Free and appropriate education—Local school agencies are required to provide "a free public education appropriate to [students'] needs" at no cost to parents. An appropriate education may include an out-of-district or private school placement if the appropriate

services cannot be provided in the district. (*T.C.A.* §49-10-103(a), (h); SBE Rule 0520-1-3-.09, Section (1)(k))

Due Process Rights—If parents disagree with school officials on aspects of a child's identification, evaluation, or individualized education program, they have the right to a due process hearing. Both the federal and state laws provide procedural safeguards for evaluation, assurances of parental consent and notification for actions, and the right to a due process hearing with an impartial hearing officer. (*T.C.A.* §49-10-601; SBE Rule 0520-1-3-.09, Section (5)(f))

Least Restrictive Environment—This means that every effort should be made to place a disabled child in the same school he or she would attend if not disabled; if this is not appropriate, a disabled student should attend school as much like the regular school and as close to the child's home as possible. In addition, a disabled child should not be separated from the regular school program or from peers of similar chronological age any more than necessary. Finally, a disabled child should be in a school setting with nondisabled children as much as possible. (*T.C.A.* §49-10-103(c)(1)-(2), (e); SBE Rule 0520-1-3-.09, Section (1)(u))

Individualized Educational Programming (IEP)—An Individual Education Program (IEP) is a written program designed and developed by parents and school system personnel (and others if needed) detailing the individual goals and services to be provided for each special education student. An IEP must be completed for each student who is classified as a special education student. It includes: the student's current level of educational performance; annual goals; specific education and related services to be provided to the student; the extent the student will participate in the regular education program; the projected dates for the initiation of services and the duration of those services; appropriate objective criteria and schedules for determining, at least annually, whether the objectives are achieved; a statement of needed transition services[3] no later than age 16, including, if appropriate, each participating agency's responsibilities or linkages, or both, before the student leaves the school setting. (*T.C.A.* §49-10-114; SBE Rule 0520-1-3-.09, Section (4)(b)1-3))

Early intervention program for infants and toddlers with disabilities—The state Department of Education is required to actively search for and provide services to disabled pre-school age children who could benefit from early intervention. The department is responsible for developing a statewide system of coordinated, comprehensive, and multidisciplinary interagency programs for infants and toddlers with

[3] "Transition services" are defined in 20 *U.S. Code* §1401(a)(19) as: "...a coordinated set of activities for a student, designed within an outcome-oriented process, which promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment, including supported employment, continuing and adult education, adult services, independent living, or community participation. The coordinated set of activities shall be based upon the individual student's needs, taking into account the student's preferences and interests, and shall include instruction, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation."

disabilities, and their families. Among other components, the law requires the department to have in place a child-find program, a public awareness program, a central directory, a comprehensive system of personnel development, procedural safeguards related to assessment, evaluations and case management services, and data collection. (*T.C.A.* §49-10-702; SBE Rule 0520-1-3-.09, Section (10))

Other provisions of Tennessee's law:

- define "children with disabilities" to include the "educable, trainable and profoundly retarded; the speech and/or language impaired; the deaf and hearing impaired; the blind and visually limited; the physically disabled and/or other health impairments including homebound and hospitalized; the learning disabled including perceptually disabled and emotionally conflicted; the multiple disabled; the intellectually gifted; and any other child whose needs and abilities cannot be served in a regular classroom setting." (T.C.A. 49-10-102) Intellectually gifted, other functionally delayed, and other developmentally delayed are categories Tennessee has chosen to include above the federal categories.
- create both the Division of Special Education in the Department of Education and the advisory council for the education of students with disabilities. (*T.C.A.* §49-10-104—105)
- authorize state financial aid for school districts providing educational and related services to disabled children. (*T.C.A.* §49-10-113)
- require each school district annually to report to the commissioner of education and the state board of education "the extent to which it is then providing the special education for children with disabilities necessary to implement fully the policy of...this chapter." (*T.C.A.* §49-10-303)

Pertinent Court Decisions

The Supreme Court finding in *Brown v. Board of Education* in 1954 paved the way for future court decisions regarding the civil rights of the disabled to receive a free, appropriate, public education. The case concerned racial segregation rather than the rights of the disabled, but it established that certain principles—notably, due process of law and equal protection under the law—should be applied to educational opportunities. These same principles were later applied to cases regarding the disabled.

Pennsylvania Association for Retarded Citizens (PARC) v. Commonwealth of Pennsylvania (1971), often cited as a landmark case for special education, was a class action suit brought to challenge the constitutionality of Pennsylvania statutes that allowed schools to exclude children on the basis of retardation. The decision in the case held that the laws were unconstitutional and that the state constitution obligated the public schools to provide a publicly supported education to handicapped children. The court found that "placement in a regular public school class is preferable to placement in a special public

school class, and placement in a separate public school class is preferable to placement in any other type of program of education and training."[4]

On November 6, 1973, an important case for Tennessee was brought soon after passage of the state's 1972 law, against the state Department of Education, "alleging certain delays in the implementation of Tennessee's Mandatory Education Law...for handicapped children and youth." The case, filed in the chancery court of Davidson County, was *Val Rainey, et al. v. Tennessee Department of Education, et al*.

According to a January 1977 memorandum filed by the Chancellor in relation to the case, as of October 1976, there were still 682 handicapped children totally excluded from education in Tennessee; 2,988 handicapped children who were enrolled in school but not receiving special education services; and 1,073 children with verified handicaps enrolled in a program but not receiving what had been recommended by multi-disciplinary teams.

The Chancellor held that the lack of equal education opportunity for handicapped children in Tennessee violated the equal protection clause of the Fourteenth Amendment of the United States Constitution and provisions of the Tennessee Constitution. He required the Department of Education to submit an implementation plan on or before March 1, 1977, describing programs to serve all children, the programs already in place, and the added costs for full implementation, and to put the plan into effect by July 1, 1977.

The plan was filed in July 1977. Since that time the Department of Education continues to report to the court, which monitors the implementation of the right to education policy.

Although Tennessee's laws concerning special education closely follow federal policy, it has been argued by some that they exceed federal requirements. The United States Court of Appeals for the Sixth Circuit, however, in *John Doe v. The Board of Education of Tullahoma City Schools,* decided that "...the Tennessee Special Education statute does not mandate a higher standard than federal law." The case was brought after parents of a child in Tullahoma, Tennessee, enrolled him in a private school specifically for children with learning disabilities. The public school had previously determined that he was eligible for special education services, convened a multidisciplinary meeting, and proposed an individualized education program (IEP). The child and the child's parents, however, chose the private placement instead and requested reimbursement from the school system. In a September 18, 1990, hearing before an administrative law judge, the ALJ ruled that the IEP was adequate and that the parents were not entitled to reimbursement. The parents appealed the decision, arguing that the Tennessee Special Education statute mandates a higher standard than the standard provided in the IDEA. The U.S. Court of Appeals found that the state statute did not exceed the federal requirements, and determined that the IEP as provided by the public school system was appropriate and represented the least restrictive appropriate environment, and that the parents, therefore, were not entitled to reimbursement.

[4] 344 F. Supp. 1257 as cited in *Issues and Research in Special Education, Vol 1.,* edited by Robert Gaylord-Ross, (1990, Teachers College Press, Columbia University), p. 116.

Appendix C
Copy of Survey

STATE OF TENNESSEE

COMPTROLLER OF THE TREASURY

OFFICE OF EDUCATION ACCOUNTABILITY

1360 Andrew Jackson Building
500 Deaderick Street
Nashville, Tennessee 37243-0268
Phone 615/532-1111
Fax 615/532-9237

Name _____

Title_____

School System _____

Mailing address _____

_____

_____

Telephone _____

Date _____

Medical Issues

1. For the 1994-95 school year, what was the total number of students in your school system for whom the following procedures were performed on a routine/regular basis? How many of these students were classified as special education? At how many *separate schools* were these children located?

	Total number of students	Special education students	Number of schools where children were located
Clean intermittent catheterization			
Sterile catheterization			
Cleaning and maintenance of a tracheostomy			
Gastrostomy tube feeding			
Blood Glucose Monitoring			
Breathing machine / nebulizer treatment			

Other procedure (please specify)			
Other procedure (please specify)			

Please use additional pages to list other procedures, if necessary.

2. For the 1994-95 school year, how many of the following administered these procedures in your school system?

Clean intermittent catheterization

	number performing service for regular education students	number performing service for special education students
teacher assistants		
teachers		
nurses	RNs: LPNs:	RNs: LPNs:
parents		
volunteers		
students (self administration)		
other (please specify)		

Sterile catheterization

	number performing service for regular education students	number performing service for special education students
teacher assistants		
teachers		
nurses	RNs: LPNs:	RNs: LPNs:
parents		
volunteers		
students (self administration)		
other (please specify)		

Cleaning and maintenance of a tracheostomy

	number performing service for regular education students	number performing service for special education students
teacher assistants		
teachers		
nurses	RNs: LPNs:	RNs: LPNs:
parents		
volunteers		
students (self administration)		
other (please specify)		

Gastrostomy Tube Feeding

	number performing service for regular education students	number performing service for special education students
teacher assistants		
teachers		
nurses	RNs: LPNs:	RNs: LPNs:
parents		
volunteers		
students (self administration)		
other (please specify)		

Administration of Medication

	number performing service for regular education students	number performing service for special education students
teacher assistants		
teachers		
nurses	RNs: LPNs:	RNs: LPNs:
parents		
volunteers		
students (self administration)		
other (please specify)		

3. During the 1994-95 school year, how many total students were administered medicine one or more times per day for a period exceeding two weeks? How many of these were special education students?

   total number of students _____
   number who are special education students _____

4. During the 1994-95 school year, how many total students were administered the prescription drug Ritalin? How many of these were special education students?

   total number of students _____
   number who are special education students _____

5. Currently which of the following apply to the procedure used to administer medicines? (Check all that apply.)

   _____medicines are kept in the school office

   _____medicines are kept by the teachers in the classroom

   _____medicines are kept secure and locked

   _____administration of prescription medicine requires a physician's order

   _____prescription medicines are in original containers with pharmacy labels

   _____students are responsible for self-administering their medicines

   _____adult supervision of student self-administration of medicine is provided

   _____a registered nurse trains staff responsible for administering medicines

   _____administration of medicine is documented each time it occurs

6. During the 1994-95 school year, how many total full-time nurses served your school system? _____
   Of these full-time nurses, how many were registered nurses (RNs)?_____ Licensed practical nurses (LPNs)?_____

   How many part-time nurses served your school system?_____
   Of these part-time nurses, how many were registered nurses (RNs)?_____ Licensed practical nurses (LPNs)?_____

   How many of the full-time nurses were employed by the school system?_____
   How many were employed by another agency, such as the local department of health? _____
   How many were contracted through a home health care agency or other health service agency? _____
   Are there agencies in your area through which you could, if necessary, secure health services? _____yes _____no

   How many of the full-time nurses served only special education students? _____

Disciplinary Issues

1. In your school system during the 1994-95 school year, how many disciplinary actions were taken against students for serious offenses (i.e., possession of weapons, property damage, drug-related, etc.)?_____
   How many of these disciplinary actions were taken against students classified under special education?_____
2. For the 1994-95 school year, specify the number of special education students who received the following types of disciplinary actions below:

No. of special education students	Type of disciplinary action taken
	In-school suspension
	Out-of-school suspension
	Expulsion
	Sent to alternative school
	Other (please specify)

3. For special education students identified in question 2 above **who were expelled or received out-of-school suspension** during the 1994-95 school year in your system, how did the school continue to provide the required services?_____
   _____
   _____
   _____
   _____
   _____

4. How does your school system apply the "zero tolerance" policy—a policy that requires expulsion for students caught with guns or other weapons at school—to special education students? _____
   _____
   _____
   _____
   _____
   _____

Thank you for completing our survey. If you would like a copy of the survey results, please check here. ❒
Please return the completed survey to the Office of Research in the enclosed self-addressed stamped envelope by September 25, 1995. You may also fax the completed survey to Kimberly Bandy or Kim Potts at 615/532-9237.

Appendix D
Federally Defined Disability Categories

The federally defined disability categories are contained in 34 Code of Federal Regulations 300.7. The terms are defined as follows:

- "Autism" means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. The term does not apply if a child's educational performance is adversely affected primarily because the child has a serious emotional disturbance, as defined in paragraph (b)(9) of 34 CFR 300.7.
- "Deaf-blindness" means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.
- "Deafness" means a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, that adversely affects a child's educational performance.
- "Hearing impairment" means an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance but that is not included under the definition of deafness above.
- "Mental retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child's educational performance.
- "Multiple disabilities" means concomitant impairments (such as mental retardation-blindness, mental retardation-orthopedic impairment, etc.), the combination of which causes such severe educational problems that they cannot be accommodated in special education programs solely for one of the impairments. The term does not include deaf-blindness.
- "Orthopedic impairment" means a severe orthopedic impairment that adversely affects a child's educational performance. The term includes impairments caused by congenital anomaly (e.g., clubfoot, absence of some member, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).
- "Other health impairment" means having limited strength, vitality or alertness, due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes that adversely affects a child's educational performance.
- "Serious emotional disturbance" is defined as follows:
  The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's

educational performance -
- An inability to learn that cannot be explained by intellectual, sensory, or health factors;
- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- Inappropriate types of behavior or feelings under normal circumstances;
- A general pervasive mood of unhappiness or depression;
- A tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have a serious emotional disturbance.

- "Specific learning disability" means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not apply to children who have learning problems that are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.
- "Speech or language impairment" means a communication disorder such as stuttering, impaired articulation, a language impairment, or a voice impairment that adversely affects a child's educational performance.
- "Traumatic brain injury" means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychological impairment, or both, that adversely affects a child's educational performance. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory; perceptual and motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital or degenerative, or brain injuries induced by birth trauma.
- "Visual impairment including blindness" means an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness.

Appendix E
Details of Federal Funding of the IDEA

Part B—Each year, the Part B program distributes funds to the states according to the total number of students with disabilities reported by each state as receiving special education and related services. On December 1 each year, the Tennessee Department of Education compiles an annual child count and submits it to the Office of Special Education Programs. The state's Part B grant for the next fiscal year is based on that count. Under Part B in 1994-95, Tennessee distributed $325 in federal money per child from age 6 to 21 who is categorized under special education and $915 (including the IDEA funds) per child from age 3 to 5; for 1995-96, the amounts increased to $415 and $1,140, respectively. Federal funds distributed under Part B from 1992-96 in Tennessee are as follows:

Federal Funds Distributed by Department of Education
Per Handicapped Student Identified and Served

	Preschool	IDEA
1992-93	$960.00	$310.00
1993-94	$1,080.00	$330.00
1994-95	$915.00	$325.00
1995-96	$1,140.00	$415.00

Source: Division of Special Education, Department of Education

Under IDEA's provisions, states must meet a number of statutory and regulatory requirements in order to receive federal financial assistance under the Part B program. Every three years the Tennessee Department of Education must submit a State Plan to the Secretary of Education for approval. The plan must meet all of the Part B requirements specified in the implementing regulations. It must include a copy of all state statutes, regulations, policies, standards, and procedures that Tennessee has established to carry out the applicable federal requirements and provide assurances that it will adhere to these requirements. The plan must also demonstrate in detail how each agency responsible for providing special education to children with disabilities is under the general supervision of the Department of Education and how each one ensures compliance with the federal and state law. State plans must be approved by the Secretary of Education before funds can be allocated.

States must distribute at least 75 percent of the funds received under Part B to local educational agencies (LEAs) for the education of students with disabilities.[1] Tennessee, however, allocates 80 percent of its Part B funds to LEAs. In turn, the LEAs must ensure that these funds are not used to supplant state and local expenditures for the education of the disabled, but instead pay for the excess costs of providing special education and related services. Of the remaining funds received under Part B, the Tennessee Department of Education uses five percent for administrative costs and 15 percent for staff development/training, development of program guides and curriculum materials, development and implementation for parent training activities, assistance to LEAs for

[1] 20 *U.S.Code* §1411(c)(1)(B).

eligible students placed by other state agencies in foster or group homes located in school districts other than where the children would normally attend school, and assistance to local school systems for some eligible students placed in high-cost residential or other high-cost facilities, or other very high cost children with disabilities who are the responsibility of the school systems. (See pages 13-15 for an explanation of how funds for high-cost children are distributed to local education agencies.)

About once every four years the Office of Special Education Programs, a division of the federal Department of Education, conducts an on-site monitoring review of each state receiving financial assistance under Part B. It uses the information collected during the review to assess the extent to which the state's approved plan is being implemented and the effectiveness of the state's systems.

Part H—The Program for Infants and Toddlers was created as Part H of the IDEA by P.L. 99-457, the Education of the Handicapped Amendments of 1986. Part H requires the states to address the needs of infants and toddlers (birth through age 2) with disabilities and their families through a statewide comprehensive, interagency, coordinated program of early intervention services. Unlike Part B funds, federal funds received under Part H are not distributed to school systems. The states have the freedom to determine the best way to expend Part H funds to provide services to infants and toddlers with disabilities.

The Tennessee Department of Education is the lead agency for Part H. It has established the Tennessee Early Intervention System (TEIS) to fulfill the federal requirements requiring early detection and services for disabled infants and toddlers. TEIS actively seeks children who may need the state's services. Staff uses various means, including referrals to their toll-free number from neighbors, doctors, teachers, and others. They contract with nine service coordinators in each of the nine development districts established by the former State Planning Office.

Preschool Grant Program—The Preschool Grant Program requires states to provide a free, appropriate public education to all eligible 3- through 5-year-olds with disabilities. States receive funds under the grant program based on the December 1 count for children ages 3 to 5 who are receiving special education and related services.

Appendix F
Data Collection

Following is a brief description of the counts taken prior to the 1995-96 school year:

- The *December 1* count is a head count of special education students with disabilities for the purpose of reporting to the U. S. Office of Special Education Programs (OSEP). This count includes all Tennessee children receiving special education services as defined by federal legislation on that date. It excludes students considered gifted, other developmentally delayed, or other functionally delayed, since these are state-funded categories only. The December count for a given year is used to determine the amount of federal funding a state will be granted under Part B for the following school year. For example, in December 1993 Tennessee had 115,601 children in federal special education categories. The federal distribution of the state's Part B grant for the next fiscal year 1994-95 was based on this count.

- As a result of the provisions of *Val Rainey, et al. v. Tennessee Department of Education, et al*, the Department provides the *October* counts to the Chancery Court of Davidson County, which monitors the implementation of the right to education policy. The October report includes the status of services children receive, the number of children suspected of being disabled, and the number of inappropriately served children. The *Rainey* case was brought soon after passage of the state's 1972 law, on November 6, 1973, against the state Department of Education, "alleging certain delays in the implementation of Tennessee's Mandatory Education Law...for handicapped children and youth." See Appendix B, page 56.

- The *February 1* counts represent the number of special education children identified and served at the various options supported by the BEP. The counts are a census taken at a specific point in time—in this case, February 1 of each school year. In addition, the February count is used to generate funds through the BEP. The counts are based on the options served, and include both primary and secondary counts. For example, a gifted child with a speech impairment would be included twice, because the child is served under both a primary and secondary option. In February 1994 there were 137,476 children being served; of these, 23,907 children had a secondary option. The 1994-95 BEP funded these 161,383 options (137,476 primary + 23,907 secondary options).

- The *June 1* count is cumulative. It is a count of the number of special education children who were identified and served anytime during the course of the school year; in other words, for a child to be counted in a system he/she is not necessarily present on June 1, but was present at some point during the school year. The total number is collected and reported in the Annual Statistical Report (ASR) as the number of children with disabilities receiving special education services (table 11). The count does not "double count" children with primary and secondary disabilities. In this case, for the purposes of the June 1 count, a gifted child with a speech impairment would

only be counted as one child. However, a child who attended school in Murfreesboro, who transferred to Rutherford County, and then to Davidson County would be counted three times. (An additional complication is encountered because special education reports include pre-school students who are not included in the ADM. Discussion of the percentage of students receiving special education services as a percentage of ADM is therefore not precise, but is commonly used to determine percentage of students being served by special education for comparative purposes.)

Appendix G
Board of Nursing Policy Statement for Delegation of School Health Services (adopted March 8, 1996, by the Board of Nursing)

The Board of Nursing adopts the National Council of State Boards of Nursing (NCSBN) 1995 Delegation Decision-Making Process, finding the standard outlined in its paper authoritative in defining the standard for Tennessee in accordance with the Board's interpretation of its law and rules.

In applying this paper to the school setting, the registered nurse is authorized to delegate to unlicensed personnel those nursing tasks supported by national standards as safe and appropriate to delegate, according to the premises and delegation decision process outlined in the NCSBN paper. Such delegation to unlicensed personnel in the school setting does not constitute the unlawful practice of nursing as long as Guidelines for "Delegation of School Health Services to Unlicensed Assistive Personnel" developed by the Department of Health are followed.

For guidance to practicing school nurses, the following tasks commonly performed in the school setting are appropriate for the RN to consider for delegation to the unlicensed person under the NCSBN Delegation Decision Process:

1. clean intermittent urinary catheterization
2. gastrostomy feeding
3. administration of oral/topical/aerosol/rectal medications under the following circumstances:
    a. The authorized and/or prescribed medication's route of administration is oral/topical/aerosol.
    b. The student's condition for which medication is authorized and/or prescribed is stable.
    c. The administration of the medicine is properly documented.

This list is not intended to limit or exclude other tasks that may be appropriately delegated.

Guidelines for Delegation of School Health Services to Unlicensed Assistive Personnel

INTRODUCTION

Children with special health needs are being found in increasing numbers in classrooms across Tennessee. It is anticipated that these numbers will continue to grow as medical technology allows more children to survive premature birth, birth defects, chronic disease and various forms of injury. Existing legal requirements mandate that all children be allowed access to educational opportunity, regardless of handicapping conditions.

While school district administrators have certain responsibilities regarding the educational placement of students, they cannot legally be responsible for deciding the level of care required by an individual student with special health care needs or who should provide that care. The registered nurse (RN) based on Tennessee's Nurse Practice Act and related state

rules and regulations or a licensed physician, determines whether care should be provided by a registered nurse, licensed practical nurse or delegated to unlicensed assistive personnel (UAP).

The RN is responsible for determining whether delegation of nursing care, including the administration of medications, is appropriate in each individual situation even if a physician or other health professional states or "orders" that such care should be provided by a UAP (unless a physician or other professional takes full responsibility for the training and supervision of the UAP). Furthermore, it must be both legally and professionally appropriate for that professional to engage in delegation of the specific health care activity to unlicensed individuals.

Statewide, the need has been recognized for an organized approach to providing for children with special health care needs in order that their needs be met efficiently, appropriately, and safely while at school. This set of guidelines was written in response to that need.

BOARD OF NURSING POLICIES

The Board of Nursing adopts the National Council of State Boards of Nursing (NCSBN) 1995 Delegation Decision-Making Process, finding the standard outlined in its paper authoritative in defining the standard for Tennessee in accordance with the Board's interpretation of its law and rules.

In applying the NCSBN paper to the school setting, the registered nurse is authorized to delegate to unlicensed personnel those nursing tasks supported by national standards as safe and appropriate to delegate, according to the premises and delegation decision process outlined in the NCSBN paper. Such delegation to unlicensed personnel in the school setting does not constitute the unlawful practice of nursing as long as Guidelines for "Delegation of School Services to Unlicensed Assistive Personnel" developed by the department of health are followed.

For guidance to practicing school nurses, the following procedures commonly performed in the school setting are appropriate for the RN to consider for delegation to the unlicensed person under the NCSBN Delegation Decision Process:

1. clean intermittent urinary catheterization
2. gastrostomy tube feeding
3. medication administration under the following circumstances
   a. The authorized and/or prescribed medication's route of administration is oral/topical/aerosol/rectal. Authority shall not extend to the administration of medications by injection, except in an emergency, life threatening situation or as permitted under Sec. 68-140-510.
   b. The student's condition for which medication is authorized and/or prescribed is stable.
   c. The administration of medication is properly documented.

This list is not intended to limit or exclude other procedures that may be appropriately delegated by the RN.

DEFINITIONS

1. Accountability—Being responsible and answerable for actions or inaction in the context of delegation.
2. Delegation—Transferring to a competent individual the authority to perform a designated health care procedure in a specific situation. Each person involved in the delegation process is accountable for his or her own actions or inaction.
3. Delegator—The registered nurse making the delegation.
4. Delegatee—The person receiving the delegated authority.
5. Licensed prescriber—as used in this document will refer to physicians, dentists, podiatrists, and certified nurse practitioners legally authorized to prescribe medications.
6. Medication—as used in this document will refer to both prescription and non-prescription drugs.
7. Prescription drugs—medications requiring a written order for dispensing and signed by a licensed prescriber.
8. Non-prescription drugs—medications which may be obtained over-the-counter without a prescription.
9. Stable—a health condition which has remained unchanged for the past four weeks and is expected to remain so OR a self limiting health condition which is expected to resolve in four weeks or less.
10. Supervision—The provision of guidance or direction, monitoring, evaluation and follow-up by the registered nurse (RN) for accomplishment of a procedure delegated to unlicensed assistive personnel.

CRITERIA FOR DELEGATION

I. Any health care procedure delegated by the RN shall be:

A. within the area of responsibility of the RN delegating the procedure,
B. within the knowledge, skills, and ability of the RN delegating the procedure,
C. a procedure that in the opinion of the delegating RN can be properly and safely performed by the unlicensed person without jeopardizing the student's welfare,
D. of a routine, repetitive nature and shall not require the delegatee to exercise independent nursing judgment or intervention,
E. limited to a specific delegatee, for a specific student and within a specific time frame.

II. The delegatee shall not further delegate the procedures delegated by the registered nurse to another individual nor may the procedures be expanded without the express written permission of the delegating RN.

III. Unlicensed assistive personnel shall successfully complete standardized training and student specific training prior to participating in delegated care.

IV. The delegating RN shall have sufficient decision-making authority, administrative support, supervisory authority and necessary resources to ensure safe care for students.

V. The delegatee has the right to request that a witness be present while a procedure is performed. A witness, in this instance, does not necessarily need to be trained in the procedure.

RESPONSIBILITY OF THE DELEGATOR

I. The delegating RN will establish that the necessary physician's order (including emergency orders), parent/guardian authorization and any other legal documentation necessary for implementing the procedure have been received before any student specific training is provided. All prescriptions and written orders for long-term medications or procedures shall be renewed at least annually.

A. If the task of prescription medication administration is delegated, an order from a licensed prescriber must be obtained and shall include:

1. Student's name
2. Licensed Prescriber Name and Signature
3. Licensed Prescriber Phone and Emergency Number(s)
4. Name of Medication
    a) dosage
    b) route of administration
    c) frequency and time of administration
5. Date of Order
6. Discontinuation Date
7. Diagnosis or Reason Medication is Needed
8. Intended Effect of the Medication
9. Possible Side Effects

B. The routine administration of medication by injection shall not be delegated.

C. Prescription drugs shall:

1. be brought to school by an individual acceptable to the school,
2. be brought to school in the original, pharmacy labeled container. The container shall display:
    a) Student's Name
    b) Prescription Number
    c) Medication Name and Dosage
    d) Administration Route or Other Directions
    e) Date
    f) Licensed Prescriber's Name
    g) Pharmacy Name, Address and Phone Number

D. Non-prescription drugs shall:

1. be brought to school by an individual acceptable to the school,

2. be brought in with the manufacturer's original label with the ingredients listed and the student's name affixed to the container,
3. require a written parental/guardian request which shall include:
a) Child's Name
b) Name and Signature of Parent/Guardian
c) Name of Medication
(1) dosage
(2) route of administration
(3) frequency and time of administration
d) Discontinuation Date
e) Reason Medication is Needed
f) Parent's/Guardians Phone Number in Case of Emergency

E. Written parent-guardian authorization requesting that medication be administered or a health care procedure be performed during school hours shall include:
1. Student's Name
2. Statement of the Health Care Procedure to be Performed
3. Parent's/Guardian's Signature
4. Parent's/Guardian's Phone Number in Case of Emergency

II. The decision to delegate shall be based on the delegator's assessment of the following:
A. Student's health needs including, but not limited to, complexity and frequency of the nursing care, and degree of immediate risk if the procedure is not carried out,
B. delegatee's knowledge, skills and abilities,
C. Nature of procedures being delegated including, but not limited to, degree of invasiveness, irreversibility, predictability of outcome and potential for harm.

III. The delegating RN shall assess the student's health care needs upon the admission of the student and at the beginning of each school year, analyze the data, and develop an individualized written care plan which identifies interventions and provides for evaluation of that care.
A. The RN provides a written care plan to be followed by the unlicensed staff member.
B. The RN shall indicate within the care plan when RN notification, reassessment, and intervention are warranted, due to change in the student's condition, the performance of the procedure, or other circumstances.
C. The RN forwards a copy of the care plan to the parent/guardian for information.

IV. Unlicensed assistive personnel shall complete general training (may include self-study or didactic) before receiving student specific training. General training shall include:
A. Review of Tennessee statutes for the practice of nursing, relevant laws, and guidelines

B. Emergencies, liability issues
C. Infection control/universal precautions
D. Medication administration procedures
E. Privacy and confidentiality
F. Exchange of information between parent/guardian and the appropriate personnel

V. The delegating RN shall instruct the UAP in the delegated procedure and/or verify the individual's competence to perform the procedure, as well as how to handle any possible associated complications. In addition to the general training, student specific training shall be done. The training needs and the length of time required for the student specific training will vary with each UAP and student for each procedure. In addition to the primary delegatee, two additional competent individuals must each complete (independently with supervision during routine daily care) a minimum of three consecutive demonstrations. A skills checklist should be utilized to document 100% accuracy in each procedure required by the student in the educational setting. Student specific training should include (all areas listed may not be appropriate for each student):

A. Review of the background information/nursing assessment and discussion of the following:
1. Pertinent information from the plan of care including:
a) The diagnosis
b) The reason for the procedure or medication
2. Psychosocial issues
3. Family concerns/strengths
3. Anatomy and physiology pertinent to the procedure or medication

B. Discuss the care plan goals and plan of action including the physician's orders and other standards of care including, when appropriate, the following:
1. Procedures
a) Name and purpose of procedure
b) Time(s) of day, length of time, duration of the order
c) Method - special instructions and considerations
d) Equipment required
(1) Purpose
(2) Type, size
(3) Safe use and maintenance
(4) Storage
e) Control of communicable diseases
(1) Handwashing
(2) Universal precautions
(3) Cleaning
(4) Immunization of both student and personnel
f) Position of the student
g) Lifting of the student
h) Position of the personnel performing procedure
i) Documentation of the procedure(s) in the student's daily record

(1) Name, date, time of day, and if appropriate length of time for the procedure
(2) Position, participation, toleration of the student
(3) Outcome of the procedure
(4) Any unusual signs and symptoms or complications
(5) If procedure withheld, reasons for withholding and subsequent action taken including individuals notified
(6) Name and signature of person performing procedure

2. Special Diet
a) Type
b) Foods Allowed
c) Amount of food and fluid
d) Documentation

3. Medications
a) Who will administer the medication
b) Name of medication, when, how often, duration
c) Expected Outcome
d) Possible side effects
e) Documentation of medication administration in the student's individual health record:
(1) Student's name
(2) Name of medication, dosage given, route, date and time administered
(3) Side effects, if present
(4) Name and signature of person administering the medication
(5) Documentation of reasons for any dosages not given and persons notified
f) Warning signs, emergencies

4. Student participation in procedures

5. Discuss contingencies
a) Emergency plans including who and when to call; information to give
b) Possible alerts - identify the more common emergencies associated with the procedure or medication

C. The termination of training for any individual shall be at the discretion of the delegating RN's judgment. The RN will determine if the UAP is unable to complete the training module or has demonstrated the inability to master the level of competency required to safely perform the specific procedure.

D. Training will be complete when in the professional judgment of the delegating RN the UAP has successfully demonstrated the following:

1. an adequate knowledge base and understanding of the procedure and expected outcome,
2. the specific techniques,
3. the identification of signs and symptoms of an impending problem or emergency and the process to follow (including notification of the delegating RN) before withholding the procedure,
4. an understanding of the communication chain,
5. <u>independent</u> (without prompting or assistance), successful performance of a sufficient number of return demonstrations (not less than 3) indicating an adequate level of competency relative to a specific procedure which the delegating RN has signed off on.

VI. The delegating RN shall communicate the care plan in writing to the delegatee, including the plan for the feedback and evaluation.

VII. For the purpose of supervision, the delegating RN shall evaluate on an ongoing basis the following:

A. the degree to which the nursing care needs of the student are being met,
B. the performance of the delegatee of the delegated procedure at least every three months,
C. the need for further instruction,
D. the need to withdraw delegation,
E. proper documentation as indicated.

VIII. The delegator shall provide supervision of all health care procedures delegated to the UAPs in accordance with the following conditions:

A. The degree of supervision required shall be determined by the delegating RN after an evaluation of factors involved including, but not limited to, the following:

1. assessment and evaluation of the condition of the student. The interval shall be determined by the delegating RN based on the nature of the procedure and the competency of the unlicensed person,
2. the training and competency, specific to the health care procedure, of the UAP to whom the procedure is delegated,
3. the nature of the procedure being delegated,
4. the proximity and availability of the delegating RN to the UAP when the procedure will be performed.

B. The delegating RN shall be readily available either in person or by telecommunication.

IX. The delegating RN determines and requires the amount and type of documentation to be done by unlicensed staff. Minimum documentation shall be consistent with V.B.1.i. and V.B.3.e.

X. The delegating RN documents activities appropriate to the nursing actions listed above.

A. Documentation of delegatee's completion of general training.

B. Documentation of training of employee for performance of delegated procedure shall include:

1. specific procedure taught,
2. method(s) of teaching procedure,
3. who taught procedure,
4. trainee/delegatee observation of RN performing the procedure for the specific student,
5. trainee/delegatee demonstration of the procedure independently (without prompting or assistance) for the student in the educational setting not less than three consecutive demonstrations at 100% accuracy,
6. trainee/delegatee completion of form for daily documentation of the procedure, following each demonstration,
7. documentation of the success or failure of the trainee/delegatee to attain the skills required to perform the procedure:

a) use a minimum skills checklist and document attainment of 100% competency of each UAP in the performance of each procedure required by the student. (File document with permanent records.)

C. Documentation of supervision of employee performing the delegated procedure.

<u>IF CARE CANNOT BE SAFELY PROVIDED IN SCHOOL</u>

After consultation with the family, student's physicians, other health care providers, other members of the school team, and appropriate consultants, the RN may determine that the level of care required by the student cannot be safely provided under current circumstances in the school. In that event, the RN should refer the student back to the initial assessment team and assist the team to reassess the student's total needs and explore alternative options for a safe and appropriate program. If such a program is not designed and the student continues in an unsafe situation, the RN should:

1. Write a memorandum to his/her immediate supervisor explaining the situation in specific detail including:

a. Recommendations for safe provisions of care in the school; or,

b. The reason the care or procedure should not be performed in school and a rationale to support this.

2. Maintain a copy of the memo for the RN's personal file.
3. Allow the supervisor a reasonable period of time to initiate action to safeguard the student.
4. If such action does not occur, forward a copy of the memo to the following, as indicated: the district superintendent and the state school nurse consultant.
5. Regularly notify his/her supervisor and others, as appropriate, that the unsafe situation continues to exist until such time as the issue is resolved.

Guidelines for Assistance with Medication Self-Administration in Schools (Adopted September 1995 by the Board of Nursing)

Introduction:

The purpose of administering medications in school is to help each child maintain an optimal state of health to enhance his or her education. Medications should be limited to those required during school hours and necessary to provide the student access to the educational program.

The intent of these guidelines is to reduce the number of medications given in school yet assure safe administration of medications for those children who require them.

These guidelines specifically address the Tennessee Board of Nursing's position on the role of unlicensed personnel in the school setting in regard to the assistance in the self-administration of medications.

Nothing in these guidelines requires schools to assist students with the self-administration of medications. However, any school which provides such assistance is required to follow these guidelines.

Definitions:

1. **Medication** - as used in this document will refer to both prescription and non-prescription drugs.
2. **Prescription drugs** - medications requiring a written order for dispensing, signed by a licensed prescriber.
3. **Non-prescription drugs** - medications which may be obtained over-the-counter without a prescription from a licensed prescriber.
4. **Licensed prescriber** - as used in this document will refer to physicians, dentists, podiatrists, and certified nurse practitioners legally authorized to prescribe medications.
5. **Long-term medications** - medication utilized for treatment of chronic illness and includes both daily and PRN (as needed) medication.
6. **Self-administration** - the ingestion, application, injection or inhalation of own medication by a student in school OR in the case of a physically challenged student, student-directed administration by a designated individual.
7. **Assisted administration** - assisting a student in the self-ingestion, application, injection or inhalation of medication according to directions of the legal prescriber; or monitoring the self-administration of medication.
8. **Authorized medications** - non-prescription drugs for which the parent or guardian has submitted a written request for administration.
9. **Unlicensed personnel** - as used in this document, any unlicensed personnel, regardless of title, to whom assisting with self-administration of medications is assigned.
10. **Competent** - a student who possesses the cognitive ability for self-administration of own medications regardless of physical capabilities.

11. **Stable** - a health condition which has remained unchanged for the past four weeks and is expected to remain so OR a self limiting health condition which is expected to resolve in four weeks or less.
12. **Accountability** - as used in this document, being responsible and answerable for actions or inactions of self or others.

Providing assistance in the self-administration of medications by unlicensed personnel in the school setting under the following circumstances does not constitute the unlawful practice of nursing.

1. The student is competent to self-administer the authorized and/or prescribed medication with assistance.
2. The student's condition for which medication is authorized and/or prescribed is stable.
3. The administration of medication is properly documented.
4. Guidelines for "The Assistance in the Self Administration of Authorized and/or Prescribed Medication by Unlicensed Personnel in the School Setting" are developed by the department of health and followed.

Guidelines:

I. Medications should be limited to those required during school hours and necessary to maintain the child in school.

A. The individual assisting with medication self-administration must visually observe the student self-administer the medication OR in the case of a cognitively competent but physically challenged student, perform that portion of self-administration for which the student is incapable.

B. Each dosage of medication shall be documented and the documentation easily retrievable. Documentation shall include date, time, dosage, route and the signature of the person assisting the child in self-administration. For prescription medications, documentation shall also include the name of the pharmacy filling the prescription. In the event a dosage is not administered as ordered, the reasons shall be entered in the record.

C. To help assure safety and accountability, supervision shall be provided to unlicensed personnel assisting with the self-administration of medication. Includes verifying the routine obtainment and filing of parental written requests and the routine documentation of medication administration.

D. A procedure shall be established for written feedback to the parent(s) or guardian regarding any problems.

E. All permission for long-term medication shall be renewed at least annually.

II. All prescription drugs given in school shall be prescribed by a licensed prescriber on an individual basis as determined by the child's health status.

A. Prescription medication must be brought to school in the original, pharmacy labeled container. The container shall display:

1. Child's Name
2. Prescription Number

3. Medication Name and Dosage
4. Administration Route or Other Directions
5. Date
6. Licensed Prescriber's Name
7. Pharmacy Name, Address and Phone Number

B. All prescriptions for long-term medications shall be renewed at least annually.

C. Changes in prescription medication shall have written authorization from the licensed prescriber.

III. All non-prescription drugs given in school shall:

A. be brought in with the manufacturer's original label with the ingredients listed and the child's name affixed to the container.

B. require a written parental/guardian request which shall include:

1. Child's Name
2. Name and Signature of Parent/Guardian
3. Name of Medication
    a) dosage
    b) route of administration
    c) frequency and time of administration
4. Discontinuation Date
5. Reason Medication is Needed
6. Parent's/Guardian's Phone Number in Case of Emergency

IV. For all prescription and non-prescription drugs a written request shall be obtained from the parent(s) or guardian requesting that medication be given during school hours. The request must include the parent's or guardian's name and phone number in case of emergency. It is the parent's or guardian's responsibility to ensure that the written request and medication are brought to the school. The parent or guardian must state that the child is competent to self-administer the medication with assistance.

V. Medications must be stored in a secure separate locked drawer or cabinet. Medications requiring refrigeration should be refrigerated in a secure area.

VI. When the duration of a medication is complete or out of date, parent/guardian shall be advised to pick up any unused portions of medication.

The parent or guardian shall be responsible at the end of the treatment regimen for removing from the school any unused medication.

VII. Nothing in these guidelines is intended to prohibit schools from allowing students with asthma from keeping prescription, metered-dose inhalers, with them and readily accessible for self-administration with parental authorization.

Alternatives to Assistance with Self-Administration of Medications Work with the licensed prescriber and the parent(s) or guardian to adjust medication administration time so administration is not needed during school hours.

Hire a registered nurse or contract with a local community agency, e.g., local health department, home health agency or local hospital for a registered nurse to come into the school and administer medication.

Have a parent or guardian come to the school to administer medication(s).

Appendix H
Provisions of States' Acts or Regulations Affecting Medical Service Delivery in Schools

State	Stipulation in State Practice Act/Regulations
Alabama	Teaching permitted, no delegation or supervision.
Alaska	Supervision, delegation, and evaluation of nursing practice permitted.
Arizona	Supervision and teaching permitted, no delegation to unlicensed personnel. Delegation and supervision to auxiliary workers within the scope of their practice, (e.g., nurse aides). Dispensing of medications by school personnel under study.
Arkansas	Supervision and teaching of "other personnel allowed."
California	School nurse may supervise "qualified, designated" school personnel to give physical care to student. Care must be under school nurse. Delegation specifically permitted under "Standards of Competent Performance."
Colorado	Delegation and supervision to unlicensed personnel permitted.
Connecticut	Scope of allowed delegable activities by nursing specialty defined.
District of Columbia	Practice Act not received for review.
Delaware	Delegation, supervision, and teaching permitted.
Florida	Delegation and supervision are not in the statute but may exist in regulations. Teaching and supervision permitted.
Georgia	Teaching and supervision permitted but no mention of delegation.
Hawaii	May teach, supervise, and delegate portions of nursing practice, but if any are improperly performed, the nurse is subject to "professional misconduct."
Idaho	"Position Statement on Role and Responsibility of School Nurse" allows delegation and teaching if there is no conflict within the practice act. Act does not specifically permit delegation.
Illinois	Supervision and teaching permitted, but not delegation.
Indiana	"Teaching, administering, delegating and evaluating nursing practice" permitted as well as delegating tasks "which assist in the nursing, medical or dental regime."
Iowa	"Position Statement" and Act permit teaching and supervision, but not delegation.
Kansas	Delegation in school setting of specific tasks permitted, but is under review—problems may have arisen. Delegation of "auxiliary patient care services" and administration of medicines by person who has completed medicines administration program permitted.
Kentucky	Regulations permit delegation. Supervision, delegation, and teaching in statute definition.
Louisiana	Allows for instructions, supervision, and delegation of "selected nursing functions approved by the Board."
Maine	Delegation to LPNs and nursing assistants permitted. Teaching permitted.
Maryland	Supervision and delegation of nursing practice permitted. Much legislative debate over issue of "forced" delegation in 1995 legislative session. (63,000 licensed nurses in state) Statute amended in 1995 session to protect

	delegator nurse's judgment.
Massachusetts	Teaching, delegation, and supervision of unlicensed personnel permitted.
Michigan	Permits delegation, teaching, and supervision by registered nurses, provided certain criteria are met, as outlined in regulations.
Minnesota	May be delegated to nursing personnel (broadly defined).
Mississippi	Delegation permitted within professional judgment of nurse. Teaching, delegation, and supervision in definition.
Missouri	Teaching and supervision of unlicensed individuals, but no delegation of nursing tasks to unlicensed personnel. State has a Special Health Care Procedures Manual for provisions of health services in a school setting.
Montana	Teaching, supervision, and delegation permitted.
Nebraska	Permits delegation, teaching, supervision implied.
Nevada	Teaching, supervision, and delegation permitted. Delegation only to other nurses, can supervise other personnel if they are "qualified."
New Hampshire	Teaching of unlicensed personnel only.
New Jersey	No delegation or supervision permitted.
New Mexico	By declaratory ruling: May delegate to non-licensed person who is prepared by education and experience to recognize and handle complications that may arise. Statute itself permits teaching and supervision, but does not mention delegation. Practice of nursing definition includes delegation of nursing interventions that may safely be performed by others and are not in conflict with the NPA.
New York	No delegation or supervision, but legislative amendment being sought.
North Carolina	May delegate to unlicensed person if six criteria are met (administrative rule). Includes "personal care" in a school setting. Supervision and teaching only contained in Act itself.
North Dakota	Teaching, supervision, and delegation of health and nursing practices permitted.
Ohio	May supervise and delegate nursing practice.
Oklahoma	Delegation, supervision, and teaching allowed.
Oregon	Declaratory ruling regarding unauthorized practice by school aides allowing CIC. Teaching and delegation permitted; supervision of "nursing assistants" allowed. "Interim" version, December 1994, remains unchanged. Delegation permitted by regulation only in certain facilities (does not include public schools).
Pennsylvania	Health teaching permitted. No mention of delegation or supervision in Act itself.
Rhode Island	Teaching permitted, but not delegation or supervision.
South Carolina	Teaching, supervision, and delegation of nursing practice permitted.
Tennessee	State legislature passed measure providing that only licensed medical professionals can perform health care procedures in schools. Unlicensed personnel can assist in the self-administration of medications to certain students.
Texas	May supervise and delegate. Texas Education Code gives immunity to school personnel administering medications.
Utah	Limited delegation in accordance with guidelines from Practice Issues Committee regarding child with Special

	Health Care Needs in School Setting. Teaching, delegating, and supervision are permitted by Act.
Vermont	Delegation and supervision permitted.
Virginia	Supervising and teaching permitted, but not delegation.
Washington	Delegation, supervision, and teaching permitted.
West Virginia	Supervision and teaching permitted, but not delegation.
Wisconsin	Delegation and supervision permitted. Under study by task force.
Wyoming	Teaching, supervision, and delegation permitted.

Source: *State Nurse Practice Acts and Unlicensed Assistive Personnel,* Revised June 1995, survey conducted/analyzed by Majorie J. Long, J.D., as part of the project "Developing Policy and Practice to Implement I.D.E.A. Related to Invasive Procedures for Children with Special Health Care Needs," funded by the U.S. Department of Education and carried out at the University of Colorado Health Sciences Center, School of Nursing, Marilyn J. Krafjicek, Ed.D., R.N., F.A.A.N., Project Director/Associate Professor.

Appendix I
Letters and Responses from the Tennessee Department of Education and the State Board of Education

TENNESSEE DEPARTMENT OF EDUCATION
ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

MEMORANDUM

TO: Ethel R. Detch, Director
Office of Education Accountability

FROM: Jane Walters

DATE: November 27, 1996

SUBJECT: Response to Special Education Report

Enclosed is the response of the Department of Education to the Special Education report prepared by your office. We appreciate the opportunity to respond. The report was very thorough and provided an excellent review of Special Education in Tennessee.

If you need additional information, please do not hesitate to call Joe Fisher, at 741-3340, on program issues, or Lynnisse Patrick, at 532-1680, on finance issues.

Enclosure

JW/cs

c: Lynnisse Patrick, Assistant Commissioner for Finance, Accountability, and Technology
Joseph Fisher, Executive Director, Division of Special Education

State of Tennessee
State Board of Education
400 Deaderick Street
Suite 200, Citizens Plaza
Nashville, Tennessee 37243-1050
615-741-2966

December 12, 1996

Ms. Ethel Detch
Director
Office of Education Accountability
Comptroller of the Treasury
1360 Andrew Jackson Building
500 Deaderick Street
Nashville, TN 37243-0268

Dear Ms. Detch:

This communication is in response to your letter of October 23, 1996, requesting an official reaction to the report on special education prepared by your office. As stated in your report, special education is a highly complex field, encompassing a myriad of issues and funding methods. We agree that we have a role to play in analyzing the special education data and insisting that the Department collect and compile accurate information on which to base program and funding decisions.

Also, we recognize that the Board has the statutory responsibility to develop a funding formula for excess costs. This issue will be addressed by the Board during the current fiscal year.

The State Board is committed to work closely with the Department in improving the inclusion provision of special education, the expanded use of assistive technology, guidelines for medical service delivery and health care as well as options for disruptive students.

We appreciate the time and effort expended by you and your staff in compiling this report. Your recommendations will provide direction to our long range planning as we continue to meet the needs of our diverse student population.

Sincerely,

J. V. Sailors
Executive Director

JVS:vlb

Trends and Data Collection
The Department of Education concurs with the recommendations on "trends" and "data collection." Based on previous analyses of special education data, it was shown to have a small error rate. However, to improve our data, we are proposing additional analyses. Through the D&A System, we currently have a mechanism for identifying any duplicates on the December census. This past year, systems were made aware of the duplicates and proceeded to delete the appropriate names from the census.

We are proposing to do a comparison analysis of data for each census count (October, December, February, and June) by comparing each system's count to the prior year's count. We will also do a comparison analysis between the four census counts using an identical report for each census period. In addition to statistical analysis, all school systems are monitored at least once every five years. Students' names are taken from a D&A census, and monitors ensure that the students are eligible for special education services. The department's Audit Section, through accountability audits of LEAs, will also continue to test for the reliability of special education data reported by LEAs on membership / attendance reports, which the state uses to calculate funding.

The State Board of Education indicates that it has "a role to play in analyzing the special education data and insisting that the Department collect and compile accurate information on which to base program and funding decisions."

Funding and Funding Methods
The department will partner with the General Assembly, the Department of Finance and Administration, and the State Board, as requested, to review the funding of special education.

The State Board of Education recognizes "that the Board has the statutory responsibility to develop a funding formula for excess costs. This issue will be addressed by the Board during the current fiscal year."

Inclusion
We concur with the recommendation.

In 1993, the Executive Directors from the Department of Education met and decided that the Department should develop a workplan which would involve key stakeholders throughout the state, along with staff from each department. This task force was given the mission to develop a "vision statement" for our future concerning education for all children in Tennessee. There were two draft reports before the final vision statement was submitted to the Commissioner. The draft reports were sent to every school, college and university in the state as well as to the disability/advocacy groups and any citizen who requested a copy. Copies were also given to Department of Education personnel. There were meetings held in regional offices and by advocacy groups to answer questions and offer clarification. We received 2,107 responses, with comments, to the draft. From these

responses, a summary was compiled, and the draft report was rewritten to reflect these findings. After this draft was reviewed by all concerned, it was submitted to the Commissioner on January 11, 1996, for approval. It was approved in February of 1996. The vision document was then sent to each department for distribution, as well as to all persons/institutes who received and/or responded to the draft reports. This paper entitled "A Shared Vision for the 21st Century" is enclosed. [OEA has a copy of this paper but did not reprint it here.] The stakeholders in this group are listed at the end of the paper.

In task force meetings we discussed developing a definition and/or policy for inclusive education. The members of the task force decided that since **inclusion is not a federal mandate**, but is a part of the continuum of services when serving children in the least restrictive environment (LRE), the federal regulations for LRE would be sufficient to use as guidelines at this time.

In 1993, personnel from the Division of Special Education began visiting school systems that were providing inclusionary educational practices. The goal was to provide additional support to school systems who were providing innovative, progressive practices using inclusive education. Staff from these agencies/programs were asked to present at conferences, and to make personnel available to answer questions and to open their schools and classes to other school systems to visit and learn from their principals and teachers. Support from the Division began with Sumner County. Presently, we support Memphis City, Dyer County, Jackson-Madison County, Davidson County, Sumner County, Cleveland City, Anderson County, Franklin County, Wilson County and Blount County. Our goal was to have systems available across the state who were different geographically as well as in size. In addition we maintain a list of schools who are providing inclusive education by utilizing a special education teacher or assistant in the regular classroom with the regular teacher. As of this date, approximately 50 school systems across the state participate. These school systems also welcome visitors and present at various conferences.

Our Department agrees that additional opportunities for staff development concerning the provision of educational strategies and classroom modifications should be provided to all school staff.

- For the past three years, personnel from the Department of Education have provided in-services to teachers and provided technical assistance when requested.
- We are collaborating with the Office of Training and Professional Development to offer courses on classroom management and effective strategies.
- We contract with five universities and four LEAs to provide technical assistance to teachers who are having difficulties with children with behavioral and/or emotional problems in order for them to remain in the regular classroom to the greatest extent possible. It is called the "Make-A-Difference Project."
- At professional conferences for school psychologists, staff from our division attend to offer training in how to encourage teachers to use strategies that make inclusion possible.

- At the 18th International Conference on Learning Disabilities, held in Nashville, individual sessions taught participants how to teach difficult content to students with special education learning problems.
- Our division offers OT/PT Workshops that focus on teaching special educators and occupational and physical therapists to collaborate in developing functional programs for children with disabilities to participate to the greatest extent possible with their non-handicapped peers.
- The Department provides institutes, workshops, and academies during the summer and throughout the school year in the areas of speech/language, gifted, preschool special education, administration of special education programs, educational interpreting and other areas of special education and related services. During 1994-95, 1,080 teachers participated in training, with approximately 30% from general education. Approximately 250 principal/building level staff teams participated in leadership training in special education.
- The Division has collaborated with Training and Professional Development Staff to develop statewide professional development activities which will meet needs of all special education, general education and vocational teachers and administrators serving students with special education needs. This training encourages support for the child with disabilities in a regular education setting.
- The State of Tennessee is following the national trend supporting collaborative training with early childhood and special education personnel. The focus is not only on collaboration, but also on the provision of educational services for young children with disabilities in natural environments. Currently, the similarities and assets of each field are being considered in the provision of inclusive training events and opportunities for administrators, direct care staff and all preschool children in Tennessee. The following activities/training events have supported the Division's effort to ensure that young children with disabilities are educated in natural environments:

  M-TYKES: Training and curriculum sharing for early childhood, Head Start, and special education personnel.

  Annual Collaborative Conferences, 1993-1996: Training attended by approximately 500 persons annually, including families, early childhood, Head Start, special education, and DHS staff, with primary emphasis on developing and supporting inclusive environments.

  Annual Head Start Conferences, 1990-present: Training attended by approximately 200 annually, with goal of promoting collaboration among early childhood community in Tennessee.

  Early Childhood Transition Training: Regional training occurring in 1994-96 designed to provide the early childhood community with an overview of mandates and components in the transition of young children into and out of programs and systems. Emphasis is always placed on services in natural environments.

  Activity Based Research to Practice Seminars: Eight Institutions of Higher Education are providing training to eighty early childhood preschool teachers on a curriculum that promotes developmentally appropriate, inclusive environments for young children.

STAIRS Project, 1995-present: This outreach project focusing on Supporting Teams providing Appropriate Inclusionary preschool practices in Rural States is currently in existence in Tennessee in Cheatham County. Two more counties will be identified by January 15, 1997, to assist in systematically identifying and addressing barriers to effective inclusion at the local level.

Presentations: The Office of Early Childhood has provided many presentations regarding the inclusion of children with special needs at every training opportunity, including the Tennessee Association of Young Children (TAYC) and the Special Education Supervisor's Conference.

Materials: The Office of Early Childhood staff distribute information regarding guidelines for LEAs providing services for children with disabilities ages 3-5 years. These guidelines discuss service delivery options to include least restrictive environment opportunities.

- The Department has moved forward to expand the techniques to the model Least Restrictive Environment for LIFE sites and other inclusive initiatives, making available and providing technical assistance to all LEAs across the state needing this assistance. Department actions include:

  Utilizing model LRE sites of best practices in integration to promote change in all other school systems and teacher training programs, through site visitations, statewide conferences, and on-site workshops and technical assistance.

  Inviting all schools to participate in the LRE for LIFE Project. Sites of best practice have been expanded from the three original LEA sites to 54 schools statewide in 1994-95.

  Expansion of technical assistance provided through a restructuring/inclusion project in West Tennessee, Restructuring for Inclusive School Environments (RISE).

Assistive Technology

We concur with the recommendation.

1. In June 1994, each LEA was allotted an additional amount of IDEA, Part B Grant Funds, based on the 1992 census of 3-21 year olds. These funds could only be used for the purchase of assistive technology services (including training), devices, equipment, and/or instructional materials for children with disabilities, ages 3-21. In subsequent years, systems were allocated approximately 25% more than their annual federal allocation and were encouraged to expend these funds on assistive technology services.
2. The Department contracts with Vanderbilt University for the development of assistive technology programs and services focusing on low vision. This partnership with Tennessee School for the Blind (TSB) and Metro Nashville Schools will result in state of the art assistive technology which could be accessed by agencies throughout the state.
3. Since 1992, the Department has offered college courses with emphasis on *assisting individuals with disabilities through technology* as an integral part of the ongoing summer institutes provided for special education, general education, and vocational teachers and administrators throughout the state. These summer programs began in the

mid 80s in response to special education training needed for teachers on waivers, and have expanded to accommodate training needs of teachers throughout the school year.

4. Collaborative training activities have been established between the Divisions of Curriculum and Instruction and Technology within the Department and the Tennessee Technology Access Project (TTAP) to develop a statewide delivery system for assistive technology training. Division of Special Education staff have been involved in planning, training, and technical assistance with these offices, and have been presenters at statewide workshops and conferences addressing assistive technology. Many of the LEAs utilize the services of TTAP Evaluation Centers in the three regions of the state to determine the most appropriate assistive technology support necessary for a student to benefit fully from an educational program in the least restrictive environment.
5. Staff from the Division are working with Training and Professional Development Staff to insure that assistive technology issues are included in training modules designed to integrate technology into the curriculum.

Health Care Services in Schools

We concur with the recommendations, except for the 3rd Administrative Alternative. [Note: OEA revised the language in that alternative.] As necessary, the department will partner with other state agencies to develop guidelines for medical service delivery and health care in schools.

...[G]uidelines have been developed to describe the provision of health care procedures, including administration of medicine and the self-administration of medicine in public and private schools. Participating in the development of these guidelines were representatives from the board of nursing, the school health nurse organization, teachers, school administrators, and the departments of health and education.

On page [30], last paragraph, the uncertainty referred to in the first sentence has been resolved. The issues in the 1994 district court decision was not what caused the department to change its decision, but rather, the decision pointed out state statutes, T.C.A. 63-6-402 and T.C.A. 63-6-410 (the nurse practice act and the respiratory therapy act) which govern the delivery of health care procedures. Also, the US Appeals Court ruled that the requesting procedure in this case should be considered a medical procedure and would constitute an undue burden for the system.

[On page 32], first paragraph, the data representing students in 1992-93 and 1993-94 school years may be misleading. It was at about this time that TBI was first counted as a separate category of disability. This does not mean that those same TBI students were not already in school and counted under some category of disability. The data does not reflect that this is the case. The data seems to indicate that there was a sudden influx of students with traumatic brain injuries. These students were already in the system, they were just not counted that way. It was also about this time when ADD/ADHD students were first counted as other health impaired under IDEA. This is the same situation as the previously discussed TBI students.

[On page 33], second paragraph, the students in the developmental centers, including Arlington, have always been counted in the federal counts of students with disabilities. This action by the Justice Department did not significantly change the responsibility in Tennessee for the provision of medical services.

[On page 38, third paragraph] seems to imply that one nurse for 3,000 students would be sufficient to provide all the health care procedures including administration of medication in Tennessee schools. This is probably not true unless students with health care needs are clustered together and housed in special schools. The distance between schools and scheduling conflicts (most medications are administered between 11 AM to 2 PM) may require a high ratio of nurses to students.

Discipline

The Department concurs with the proposal in principle but we urge the OEA to include the State Department of Education in the recommendation. [Note: OEA revised the recommendation accordingly.]

[On page 46, section titled "Disciplinary procedures for Section 504 students"]: ...While each special education student is also protected under Section 504, the federal law regarding discrimination of disabled students goes beyond special education students and includes students who are not eligible under Special Education. This section talks about students who are not in special education. Section 504 students discussed in this section are the responsibility of General Education and not Special Education. Further, this section does not add any rights or language which has not already previously been stated in the above paragraphs of the report which deal with discipline of special education students. ...Consideration should be given to removing from the report the paragraphs which reference Section 504 students who are not special education.

In addition, the State Board of Education indicates that it "is committed to work closely with the Department in improving the inclusion provision of special education, the expanded use of assistive technology, guidelines for medical service delivery and health care as well as options for disruptive students."